Case Number:	CM15-0183470		
Date Assigned:	09/24/2015	**Date of Injury:**	09/23/2012
Decision Date:	10/30/2015	**UR Denial Date:**	08/27/2015
Priority:	Standard	**Application Received:**	09/17/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a (n) 38-year-old female, who sustained an industrial injury on 9-23-12. The injured worker was diagnosed as having bilateral knee ACL tear, bilateral knee MCL partial tear and bilateral knee LCL partial tear. The physical exam (1-8-15 through 5-15-15) revealed 6-7 out of 10 pains in the bilateral knees and decreasing flexion and extension of the bilateral knees. Treatment to date has included an EMG-NCS on 8-14-15 of the lower extremities with normal results, a right knee MRI on 7-23-15 showing a medial meniscus tear and fragmentation of the posterior horn and body segment and a left knee MRI on 7-20-15 showing a medial meniscus tear and maceration of the posterior horn and body. As of the PR2 dated 7-30-15, the injured worker reports burning bilateral knee pain and muscle spasms. She rates her pain 5 out of 10. Objective findings include tenderness to palpation over the medial and lateral joint lines, right knee flexion 85 degrees and extension -10 degrees and left knee flexion 105 degrees and extension -15 degrees. The treating physician requested an MRI of the right knee and an MRI of the left knee. The Utilization Review dated 8-27-15, non-certified the request for an MRI of the right knee and an MRI of the left knee.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

MRI of the left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies.

Decision rationale: Per MTUS guidelines, special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. The position of the American College of Radiology (ACR) in its most recent appropriateness criteria list the following clinical parameters as predicting absence of significant fracture and may be used to support the decision not to obtain a radiograph following knee trauma: 1) Patient is able to walk without a limp. 2) Patient had a twisting injury and there is no effusion. The clinical parameters for ordering knee radiographs following trauma in this population are: 1) Joint effusion within 24 hours of direct blow or fall. 2) Palpable tenderness over fibular head or patella. 3) Inability to flex knee to 90 degrees most knee problems improve quickly once any red-flag issues are ruled out. For patients with significant hemarthrosis and a history of acute trauma, radiography is indicated to evaluate for fracture. Reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a problem that was present before symptoms began, and therefore has no temporal association with the current symptoms. Even so, remember that while experienced examiners usually can diagnose an ACL tear in the non-acute stage based on history and physical examination, these injuries are commonly missed or over diagnosed by inexperienced examiners, making MRIs valuable in such cases. Also note that MRIs are superior to arthrography for both diagnosis and safety reasons. In this case, the injured worker had an MRI of the left knee on 7-20-15 showing a medial meniscus tear and maceration of the posterior horn and body. It is unclear why another MRI is being requested, as there have been no interval changes since the previous MRI. The request for MRI of the left knee is determined to not be medically necessary.

MRI of the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies.

Decision rationale: Per MTUS guidelines, special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. The position of the American College of Radiology (ACR) in its most recent appropriateness criteria list the following clinical parameters as predicting absence of significant fracture and may be used to support the decision not to obtain a radiograph following knee trauma: 1) Patient is able to walk without a limp. 2) Patient had a twisting injury and there is no effusion. The clinical parameters for ordering knee radiographs following trauma in this population are: 1) Joint effusion within 24 hours of direct blow or fall. 2) Palpable tenderness over fibular head or patella. 3) Inability to flex knee to 90 degrees most knee problems improve quickly once any red-flag issues are ruled out. For patients with significant hemarthrosis and a history of acute trauma, radiography is indicated to evaluate for fracture. Reliance only on imaging studies to evaluate the source

of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a problem that was present before symptoms began, and therefore has no temporal association with the current symptoms. Even so, remember that while experienced examiners usually can diagnose an ACL tear in the non-acute stage based on history and physical examination, these injuries are commonly missed or over diagnosed by inexperienced examiners, making MRIs valuable in such cases. Also note that MRIs are superior to arthrography for both diagnosis and safety reasons. In this case, the injured worker had an MRI of the right knee on 7-23-15 showing a medial meniscus tear and fragmentation of the posterior horn and body segment. It is unclear why another MRI is being requested, as there have been no interval changes since the previous MRI. The request for MRI of the right knee is determined to not be medically necessary.