

Case Number:	CM15-0202537		
Date Assigned:	10/19/2015	Date of Injury:	12/27/2006
Decision Date:	12/01/2015	UR Denial Date:	09/24/2015
Priority:	Standard	Application Received:	10/14/2015

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 35 year old female, who sustained an industrial injury on December 27, 2006. The initial symptoms reported by the injured worker are unknown. The injured worker was currently diagnosed as status post right shoulder arthroscopic rotator cuff and glenohumeral joint extensive debridement with mini-open rotator cuff repair 01-10-08, right shoulder sprain with impingement, status post left knee arthroscopic subtotal medial meniscectomy 02-22-08, status post left knee arthroscopic partial medial meniscectomy, chondroplasty of the medial femoral condyle and lateral release, lumbosacral musculoligamentous strain and sprain, status post left hip arthroscopic surgery and right knee sprain. Treatment to date has included surgery, chiropractic treatment with benefit, physical therapy and medication. On August 24, 2015, the injured worker complained of low back pain and ongoing left knee pain. Objective findings were noted as unchanged. At the time of the exam, she was noted to have three more chiropractic sessions, which were helping. Her current knee brace was noted to be worn down. The treatment plan included left knee MRA, continuation of chiropractic treatment, continuation of pain management and a new left knee brace. On September 24, 2015, utilization review denied a request for left knee MRI arthrogram.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left knee MRI arthrogram: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg Chapter - MR Arthrography.

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 is status post left knee arthroscopic subtotal medial meniscectomy 02-22-08, and left knee arthroscopic partial medial meniscectomy. The most recent physical examination available for review revealed a non-remarkable left knee examination and there was no rationale included for requesting an MRA. Additionally, MRI is preferred to MRA, therefore, the request for left knee MRI arthrogram is not medically necessary.