Case Number:	CM15-0204965		
Date Assigned:	10/21/2015	**Date of Injury:**	02/08/2012
Decision Date:	12/09/2015	**UR Denial Date:**	09/28/2015
Priority:	Standard	**Application Received:**	10/19/2015

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: Iowa, Illinois, California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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:

This is a 63 year old male with a date of injury of February 8, 2012. A review of the medical records indicates that the injured worker is undergoing treatment for internal derangement of the right knee, and left knee pain. Medical records dated July 1, 2015 indicate that the injured worker complained of increasing right knee pain and swelling of the right knee. A progress note dated August 31, 2015 documented complaints of improved right knee pain and worsening left knee pain. The physical exam dated July 1, 2015 reveals crepitus of the bilateral knees with limited range of motion. The progress note dated August 31, 2015 documented a physical examination that showed crepitus of the bilateral knees with limited range of motion, and tenderness of the left knee anterior and medial joint line. Treatment has included physical therapy, right knee arthroscopy with medial and partial lateral meniscectomy and chondroplasty (May 7, 2015), and right knee cortisone injections. The utilization review (September 28, 2015) non-certified a request for magnetic resonance imaging arthrogram of the left knee and bilateral knee Synvisc injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI arthrogram of the left knee: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies, Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, MRI's (magnetic resonance imaging).

Decision rationale: ACOEM notes, "Special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation". "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." ODG further details indications for MRI: Acute trauma to the knee, including significant trauma (e.g., motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption. Non-traumatic knee pain, child or adolescent: non-patella-femoral symptoms. Initial anteroposterior and lateral radiographs non-diagnostic (demonstrate normal findings or a joint effusion). Next study if clinically indicated and if additional study is needed. Non-traumatic knee pain, child or adult, Patellofemoral (anterior) symptoms. Initial anteroposterior, lateral, and axial radiographs non-diagnostic (demonstrate normal findings or a joint effusion). If additional imaging is necessary and if internal derangement is suspected. Non-traumatic knee pain, adult, Non-trauma, non-tumor, non-localized pain. Initial anteroposterior and lateral radiographs non-diagnostic (demonstrate normal findings or a joint effusion). If additional studies are indicated, and if internal derangement is suspected. Non-traumatic knee pain, adult - non-trauma, non-tumor, non-localized pain. Initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement (e.g., Peligrini Stieda disease, joint compartment widening). Repeat MRIs: Post-surgical if need to assess knee cartilage repair tissue. (Ramappa, 2007) Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended. (Weissman, 2011) The treating physician documents worsening chronic left knee pain, tenderness, and positive special test on physical exam that would warrant an MRI of the left knee and meet the above guidelines. As such, the request for MRI arthrogram of the left knee is medically necessary.

Synvisc, bilateral knees, one injection: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Hyaluronic acid injections.

Decision rationale: Synvisc is a high molecular weight hyaluronan. MTUS is silent regarding the use of synvisc injections. While ACOEM guidelines do not specifically mention guidelines for usage of ultrasound guided orthovisc injections, it does state that "Invasive techniques, such as needle aspiration of effusions or prepatellar bursal fluid and cortisone injections, are not

routinely indicated. Knee aspirations carry inherent risks of subsequent intraarticular infection." ODG recommends as guidelines for Hyaluronic acid injections "Patients experience significantly symptomatic osteoarthritis but have not responded adequately to recommended conservative nonpharmacologic (e.g., exercise) and pharmacologic treatments or are intolerant of these therapies (e.g., gastrointestinal problems related to anti-inflammatory medications), after at least 3 months. Documented symptomatic severe osteoarthritis of the knee, which may include the following: Bony enlargement; Bony tenderness; Crepitus (noisy, grating sound) on active motion; Less than 30 minutes of morning stiffness; No palpable warmth of synovium; Over 50 years of age. Pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease; Failure to adequately respond to aspiration and injection of intra-articular steroids. ODG states that this RCT found there was no benefit of hyaluronic acid injection after knee arthroscopic meniscectomy in the first 6 weeks after surgery, and concluded that routine use of HA after knee arthroscopy cannot be recommended." Additionally, ODG states that Hyaluronic acid injections are generally performed without fluoroscopic or ultrasound guidance. The treating physician documents physical exam and subjective findings to meet the guidelines above. As such, the request for Synvisc, bilateral knees, one injection is medically necessary.