MAXIMUS Federal Services

Case Number:	CM15-0223638		
Date Assigned:	11/18/2015	Date of Injury:	12/04/2013
Decision Date:	12/31/2015	UR Denial Date:	10/15/2015
Priority:	Standard	Application Received:	11/13/2015

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: Texas, California Certification(s)/Specialty: Family Practice

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 58 year old male injured worker suffered an industrial injury on 12-4-2013. The diagnoses included medical and patellofemoral arthrosis right knee and post ACL reconstruction and then revision reconstruction and meniscectomy right knee. On 10-2-2015, the provider reported pain to the left knee with swelling. Since the surgeries, that the injured worker had constant pain in the left knee and had been unable to complete full physical therapy. He reported pain, weakness, swelling, stiffness and locking of the left knee. On exam, there was tenderness to the medical joint line. The right knee had no physical exam findings. Physical examination of the right knee revealed no effusion, no swelling, no crepitus and negative patellar grind test. The provider noted radiographs (undated) of the left knee show about a 50% joint space narrowing in the medal and lateral compartment and slight subluxation. Prior treatments included physical therapy, medication, activity modification and braces. On 6-1-2015, the provider noted left knee ACL reconstruction with Right knee arthroscopy with degenerative arthritis. On 7-29-2015, the provider noted left knee pain 7 out of 10 with crepitation on range of motion. It was not clear if the affected knee was left or right as the note 10-2-2015 mentions diagnoses of the right knee and symptoms of the left knee. Request for Authorization date was 10-8-2015. Utilization Review on 10-15-2015 determined non-certification for MRI of the right knee. The patient's surgical history includes left knee surgery in 1998, 2003 and right knee surgery in 2004. The medication list includes Flexeril, Lunesta, Ibuprofen, and Neurontin.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Diagnostic Criteria, Special Studies.

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

Decision rationale: Request: MRI of the right knee. Per the ACOEM guidelines cited above, "Special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. 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." Any of these indications for a right knee MRI were not specified in the records provided. The right knee had no physical exam findings. Physical examination of the right knee revealed no effusion, no swelling, no crepitus and negative patellar grind test on 10/2/15. A detailed right knee examination including tests for internal derangement like the Mc Murrays test, Anterior drawer test and tests for instability were not specified in the records provided. The patient has received an unspecified number of PT visits for this injury. The patient did not have abnormal findings in the physical examination suggestive of significant internal derangement. The history or physical examination findings do not indicate pathology including cancer, infection, or other red flags. A detailed response to previous conservative therapy was not specified in the records provided. A recent knee X-ray report is not specified in the records provided. A plan for an invasive procedure of the right knee was not specified in the records provided. The rationale for a right knee MRI was not specified in the records provided. The medical necessity of the request for MRI of the right knee is not fully established in this patient.