

<b>Case Number:</b>	CM15-0088457		
<b>Date Assigned:</b>	07/15/2015	<b>Date of Injury:</b>	08/09/2012
<b>Decision Date:</b>	08/10/2015	<b>UR Denial Date:</b>	05/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2015

### 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: North Carolina  
 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 injured worker was a 59-year-old male, who sustained an industrial injury, August 9, 2012. The injury was sustained when the injured worker was wearing a tool belt and carrying a ladder while walking on a platform where there was a 3-inch hose on the floor. Someone pulled on the hose while the injured worker was walking by, the injured worker tripped over it and fell to the floor. The injured worker landed on both knees and on the right side. The injured worker previously received the following treatments cervical neck MRI, lumbar spine MRI, left knee MRI on February 8, 2015, functional capacity evaluation, Naproxen, crutches for ambulation, right knee surgery in December of 2012, 40 sessions physical therapy, acupuncture and electrical shock wave stimulation. The injured worker was diagnosed with left knee degenerative joint disease, right knee status post arthroscopic surgery with degenerative joint disease. According to progress note of April 17, 2015, the injured worker's chief complaint was bilateral knee pain left greater than the right. The injured worker was complaining of the left knee locking and giving way as well as the right knee but fewer symptoms. The injured worker walked with a cane. The physical exam of the right knee noted well healed surgical portals. There was pain with full extension. The range of motion was 0 to 115 degrees. There was pain over the medial aspect of the joint. The examination of the left knee noted varus lower. There was a soft end-point to Lachman testing. There was crepitus with motion and use of a cane. The range of motion was 5 to 100 degrees. The treatment plan included x-rays of the right knee and left knee.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**X-ray of the right knee:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 20th annual edition & ODG Treatment in Workers' Comp (13 annual edition), 2015, Knee and Leg Chapter, Indications for Imaging -X-rays.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints  
Page(s): 342-343.

**Decision rationale:** The ACOEM chapter on knee complaints and imaging states: The clinical parameters for ordering knee radiographs following trauma in this population are: Joint effusion within 24 hours of direct blow or fall. Palpable tenderness over fibular head or patella. Inability to walk (four steps) or bear weight immediately or within a week of the trauma-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. Table 13-5 provides a general comparison of the abilities of different techniques to identify physiologic insult and define anatomic defects. Review of the provided clinical documentation and physical exam does not meet criteria as listed above for knee x-ray and therefore the request is not medically necessary.

**X-ray for the left knee:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 20th annual edition & ODG Treatment in Workers' Comp (ODG-TWC), 13th annual edition, 2015, Knee and Leg chapter, Indications for imaging - X-rays.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints  
Page(s): 342-343.

**Decision rationale:** The ACOEM chapter on knee complaints and imaging states: The clinical parameters for ordering knee radiographs following trauma in this population are: Joint effusion within 24 hours of direct blow or fall. Palpable tenderness over fibular head or patella. Inability to walk (four steps) or bear weight immediately or within a week of the trauma. 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. Table 13-5 provides a general comparison of the abilities of different techniques to identify physiologic insult and define anatomic defects. Review of the provided clinical documentation and physical exam does not meet criteria as listed above for knee x-ray and therefore the request is not medically necessary.