

Case Number:	CM15-0231386		
Date Assigned:	12/07/2015	Date of Injury:	03/27/2015
Decision Date:	01/15/2016	UR Denial Date:	11/18/2015
Priority:	Standard	Application Received:	11/24/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 75 year old male, who sustained an industrial injury on March 27, 2015, incurring, head, upper and lower and bilateral knee injuries. He was diagnosed with head contusion, cervical strain, cervical radiculopathy, lumbar strain, lumbar radiculopathy, and bilateral knee internal derangement and contusions. Treatment included muscle relaxants, trigger point injection, anti-inflammatory drugs, oral steroids, back brace, steroid knee injections and activity restrictions and modifications. Currently, the injured worker complained of persistent bilateral knees pain. He reported decreased pain levels and improvement from the steroid injections in his knees. He reported increased pain with climbing the stairs, squatting and activities of daily living. He noted some anterior knee giving way at times. Upon examination, the bilateral knees were tender with some slight effusion. There was no muscle atrophy and there was full range of motion. He was diagnosed with bilateral knee osteoarthritis and chondromalacia. The treatment plan that was requested for authorization included a Magnetic Resonance Imaging for the bilateral knees. On November 16, 2015, a request for a Magnetic Resonance Imaging of the bilateral knees was denied by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (Magnetic Resonance Imaging) for bilateral knees: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, MRI's (magnetic resonance imaging).

Decision rationale: Per the ODG guidelines regarding MRI of the knee: Recommended as indicated below. Soft-tissue injuries (meniscal, chondral surface injuries, and ligamentous disruption) are best evaluated by MRI. (ACR, 2001) See also ACR Appropriateness Criteria. Diagnostic performance of MR imaging of the menisci and cruciate ligaments of the knee is different according to lesion type and is influenced by various study design characteristics. Higher magnetic field strength modestly improves diagnostic performance, but a significant effect was demonstrated only for anterior cruciate ligament tears. (Pavlov, 2000) (Oei, 2003) A systematic review of prospective cohort studies comparing MRI and clinical examination to arthroscopy to diagnose meniscus tears concluded that MRI is useful, but should be reserved for situations in which further information is required for a diagnosis and indications for arthroscopy should be therapeutic, not diagnostic in nature. Indications for imaging MRI (magnetic resonance imaging): Acute trauma to the knee, including significant trauma (e.g, motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption. Nontraumatic knee pain, child or adolescent: Nonpatellofemoral symptoms. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion). Next study if clinically indicated. If additional study is needed. Nontraumatic knee pain, child or adult: Patellofemoral (anterior) symptoms. Initial anteroposterior, lateral, and axial radiographs nondiagnostic (demonstrate normal findings or a joint effusion). If additional imaging is necessary and if internal derangement is suspected. Nontraumatic knee pain, adult: Nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion). If additional studies are indicated and if internal derangement is suspected. Nontraumatic knee pain, adult: Nontrauma, nontumor, nonlocalized 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) Per progress report dated 9/8/15, it was noted, "On examination of both knees, there is a patellar ballottement with effusion. Mild atrophy in musculature of the knee. The lower extremity is neurovascularly intact. Patellofemoral examination shows significant facet tenderness with negative apprehension. There is tenderness along the medial and lateral joint lines with a positive McMurray exam. Full range of motion shown in the knee. Ligament examination to both A/P as well as varus valgus is within normal limits." The treating physician noted that MRI was recommended to rule out internal derangement and a meniscus tear. Per the citation above, MRI is indicated for non-traumatic knee pain if radiographs demonstrate normal findings. X-ray of the right knee revealed mild bony arthritis and degenerative changes. The joint spaces are fairly symmetric. The patella is well located on the Merchant view. The bone density is normal. X-ray of the left knee revealed no bony arthritis or degenerative changes. The joint spaces are symmetric and the patella is well located on the Merchant view. The bone density is normal. I respectfully disagree with the UR physician's denial based upon a lack of previous conservative therapy for the bilateral knees. Considering the chronicity of the injury, there is a very high probability that physical therapy has been done and that this has been a longstanding problem. The request is medically necessary.