

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM15-0244214 |                              |            |
| <b>Date Assigned:</b> | 12/23/2015   | <b>Date of Injury:</b>       | 06/02/2010 |
| <b>Decision Date:</b> | 01/28/2016   | <b>UR Denial Date:</b>       | 12/10/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/15/2015 |

### 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 is a 51 year old female, who sustained an industrial injury on 6-2-10. The injured worker was being treated for left knee lateral compartment degenerative joint disease and worsening compensatory low back pain related to antalgia. On 9-8-15 and 12-1-15, the injured worker complains of left knee pain with walking after sitting for prolonged time and pain in back with radiation to leg; she rates the pain 9 out of 10. The pain is predominantly in medial aspect of left knee and is improved with rest and medications. Work status is noted to be permanent and stationary. Physical exam performed on 9-8-15 and 12-1-15 revealed mild effusion of left knee, marked medial joint line tenderness, mild joint line tenderness and positive patella grind. Treatment to date has included oral medications including Ibuprofen and Omeprazole, physical therapy, home exercise program and activity modifications. On 12-3-15 request for authorization was submitted for MRI of left knee. There are no recent x-ray films submitted for review. On 12-10-15 request for MRI of left knee was non-certified by utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the left knee without contrast:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee Chapter, MRI (Magnetic Resonance Imaging).

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

**Decision rationale:** The ACOEM chapter on knee complaints and imaging states: 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 nonacute stage based on history and physical examination, these injuries are commonly missed or overdiagnosed 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. The patient does not have documented physical exam findings of knee instability or significant limitation in range of motion. Therefore the request is not medically necessary.