

Case Number:	CM13-0034070		
Date Assigned:	12/06/2013	Date of Injury:	05/03/2010
Decision Date:	09/26/2014	UR Denial Date:	09/26/2013
Priority:	Standard	Application Received:	10/11/2013

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in Rhode Island. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 41 year old patient who sustained injury on May 3 2010. On Jul 15 2010 he underwent left knee arthroscopic surgery. He had right knee arthroscopy on Jun 19 2013. This patient was seen on Aug 27 2013 for right patellar pain. He was status post arthroscopic debridement of the right knee and arthroscopy of the left knee. He had ongoing pain in both knees.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRA of 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.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343. Decision based on Non-MTUS Citation ODG- KNEE AND LEG PROCEDURE.

Decision rationale: Per ACOEM, it is indicated that 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 notemporal association with the current symptoms. Per ODG, there are indications for MRI: acute trauma to the knee, including significant trauma(eg motor vehicle accident) or if suspect posterior knee dislocation or ligament or cartilage disruption;

nontraumatic knee pain, child or adolescent; non patellofemoral 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 radiograms nondiagnostic(demonstrate normal findings or a joint effusion). additional imaging is necessary, and if internal derangement is suspect. Nontraumatic knee pain, adult. Nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs(demonstrate normal findings or a joint effusion). If additional studies are indicated, and if internal derangement is suspected. Nontraumatic knee pain, adult-non trauma, nontumor, nonlocalized in. Initial anteroposterior and lateral radiographs(demonstrate evidence of internal derangement, eg peligrini stieda disease, joint compartmentidening). Repeat MRIs: post surgical if need to assess knee cartilage repair tissue(Ramappa 2007).MR arthrography is recommended as a postoperative option to help diagnose suspected residual or recurrent tear , for meniscal repair or for meniscal resection of more than 25% who did not have severe degenerative arthrosis, avascular necrosis, chondral injuries, native joint fluid that extends into a meniscus, or a tear in a new area, MR arthrography was useful in the diagnosis of residual or recurrent tear. Patients with less than 25% meniscal resection did not need MR arthrography(Magee 2003)Based on the clinical documentation provided, there is no clinical evidence to show that the patient was treated and failed any conservative intervention nor had an indication for MRI/MRA of the knee.