

<b>Case Number:</b>	CM14-0124482		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	06/05/2011
<b>Decision Date:</b>	11/21/2014	<b>UR Denial Date:</b>	07/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/06/2014

### 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 Occupational Medicine and is licensed to practice in California. 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 48 year old woman with a date of injury of 06/05/2011 sustained while bending over to move 30 lb boxes and developed sudden onset low back pain. She has had MRI for her lumbar spine in 2011 and received electric nerve stimulation and several other interventions for her lower back symptoms. She has previously been diagnosed with bilateral knee sprain. She had an examination on 01/23/2014, which did not demonstrate any evidence of edema, effusion or instability around the knee and also does not identify the knee in the problem list. A 05/21/2014 examination reveals decreased range of motion (ROM) in both knees with flexion as well as positive bilateral McMurrays sign and also identifies bilateral knee pain, right>left in the diagnosis list. During that evaluation she reports having 6/10 right knee pain worse with driving, sitting and bending. Treatment to Date: Mostly indicated for her low back pain symptoms include medication therapy (gabapentin, lidoderm pathes and Methoderm), transcutaneous electrical nerve stimulation (TENS), physical therapy (six visits), chiropractor treatment, acupuncture therapy, and cognitive behavioral therapy (twelve visits).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Magnetic Resonance Imaging (MRI) of the bilateral knees:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation ODG Knee & Leg (updated 6/5/14) MRIs (magnetic resonance imaging)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints  
Page(s): 335-336.

**Decision rationale:** CA MTUS recommends MRI for an unstable knee with documented episodes of locking, popping, giving way, recurrent effusion, clear signs of a bucket handle tear, or to determine extent of anterior cruciate ligament (ACL) tear preoperatively. The guideline also recommends an MRI for an unstable knee with documented episodes of locking, popping, giving way, recurrent effusion and clear signs of a bucket handle tear, to determine extent of ACL tear preoperatively. In the absence of red flags, diagnostic testing is not generally helpful in the first 4-6 weeks. Knee MRIs are typically used in clinical settings to evaluate for tears in the soft tissues around the joint as well as the symptoms of instability characterized in the guidelines above. Knee instability and evidence of effusion are highly sensitive markers. However, knee pain, tenderness and swelling alone (the symptoms in this patient) are insufficient and do not address the need for MRI. These symptoms are, instead, more indicative of a bone or joint pathology, which can be adequately demonstrated with plain films. Having a positive McMurry's test is also not an indication for an MRI because the value of that test as a screening tool for medial meniscal tears is limited to a sensitivity of 53%. Therefore, the request for bilateral knee MRI is not medically necessary.