

<b>Case Number:</b>	CM14-0065350		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	12/08/2003
<b>Decision Date:</b>	05/27/2015	<b>UR Denial Date:</b>	04/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2014

### 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. 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 (IW) is a 68 year old male who sustained an industrial injury on 12/08/2003. He reported pain in the right and left knees. The injured worker was diagnosed as having status post left knee arthroscopy with partial medial meniscetomy and lateral meniscetomy, performed on 08/12/1999 with x-ray 2011 showing degenerative joint disease, and status post right knee arthroscopy with partial medial meniscetomy, lateral meniscetomy, chondroplasty and synovectomy 08/12/2003 with severe degenerative joint disease of the medial and lateral joint lines and patellofemoral joint and chondromalacia, with post-operative menisci changes per MR arthrogram dated 09/01/2004. Treatment to date has included medications and home exercise program. Currently, the injured worker complains of the right knee "Popping Out" and locking with left ankle pain. Requests for authorization for Motrin 800mg #120; Diagnostic Ultrasound of the Right Knee; and 1 Updated X-Ray of the Bilateral Knees were submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Diagnostic Ultrasound 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 (ODG) Official Disability Guidelines.

**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 studies states: Special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. The position of the American College of Radiology (ACR) in its most recent appropriateness criteria list the following clinical parameters as predicting absence of significant fracture and may be used to support the decision not to obtain a radiograph following knee trauma: Patient is able to walk without a limp. Patient had a twisting injury and there is no effusion. 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. The provided clinical documentation for review does not meet criteria for imaging of the knee and therefore the request is not medically necessary.

### **1 Updated X-Ray of the Bilateral Knees: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343.

**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 studies states: Special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. The position of the American College of Radiology (ACR) in its most recent appropriateness criteria list the following clinical parameters as predicting absence of significant fracture and may be used to support the decision not to obtain a radiograph following knee trauma: Patient is able to walk without a limp. Patient had a twisting injury and there is no effusion. 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. The provided clinical documentation for review does not meet criteria for imaging of the knee and therefore the request is not medically necessary.