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| <b>Case Number:</b>   | CM15-0111092 |                              |            |
| <b>Date Assigned:</b> | 06/17/2015   | <b>Date of Injury:</b>       | 06/19/2014 |
| <b>Decision Date:</b> | 07/16/2015   | <b>UR Denial Date:</b>       | 06/03/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/09/2015 |

### 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

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 was a 49 year old male, who sustained an industrial injury, June 19, 2014. The injured worker previously received the following treatments Norco, arthroscopic surgery on the right knee, 2 cortisone injections and anti-inflammatory medications, physical therapy, right knee MRI on April 20, 2015, right knee x-rays and peripheral nerve block. The injured worker was diagnosed with right knee strain, right ankle sprain, right internal knee derangement, right knee partial medial meniscectomy, and chondroplasty and ACL reconstruction on August 26, 2014. According to progress note of April 30, 2015, the injured workers chief complaint was right knee pain. The injured worker was walking with a cane. The injured worker was not complaining of instability. The physical exam noted well healed incisions. There was still quadriceps atrophy. There was tenderness to palpation anteriorly over the patella and medially over the medial femoral condyle and medial joint line. The treatment plan included right knee MRI.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI Right Knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints  
Page(s): 335, 343-345.

**Decision rationale:** Per MTUS guidelines, 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: 1) Patient is able to walk without a limp. 2) Patient had a twisting injury and there is no effusion. The clinical parameters for ordering knee radiographs following trauma in this population are: 1) Joint effusion within 24 hours of direct blow or fall. 2) Palpable tenderness over fibular head or patella. 3) 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 associations 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. There is no supporting documentation that the injured worker has failed with conservative treatment and he recently had an MRI of the right knee on 04/30/15. It is unclear why a repeat MRI is being requested so soon after the previous MRI. The request for MRI right knee is determined to not be medically necessary.