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| <b>Case Number:</b>   | CM15-0171174 |                              |            |
| <b>Date Assigned:</b> | 09/11/2015   | <b>Date of Injury:</b>       | 02/11/2009 |
| <b>Decision Date:</b> | 10/13/2015   | <b>UR Denial Date:</b>       | 08/19/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/31/2015 |

### 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 66-year-old male, who sustained an industrial injury on February 11, 2009. He reported an injury to his bilateral knees. An evaluation on August 7, 2015 revealed the injured worker had 122 degrees range of motion of the right knee and 130 degrees range of motion of the left knee. His motor strength on the left quadriceps and hamstring muscles was graded as 5-5 on the left and 4-5 on the right. He reported temporary relief of symptoms from a steroid injection to his left knee and no relief from a steroid injection to his right knee. The injured worker's sensation is normal in the bilateral lower extremities at the L2, L3, L4, L5 and S1 dermatomes. A physician's evaluation on August 11, 2015 revealed that the injured worker reported bilateral knee pain and discomfort. On physical examination, the injured worker had tenderness to palpation over the bilateral patella, the bilateral medial and lateral joint lines. He has bilateral crepitation and positive bilateral McMurray's sign to the bilateral knees. The injured worker was diagnosed as having status post right knee osteotomy, status post left knee osteotomy, status post right knee medial and lateral meniscectomy, status post right knee chondroplasty, status post right knee hardware removal, chondromalacia of the right knee and persistent post-operative pain of the bilateral knees. Treatment to date has included left knee surgery, multiple surgical procedures to the right knee, post-operative physical therapy, injections in the bilateral knees, and diagnostic imaging. A request for magnetic resonance angiogram of the bilateral knees to evaluation for bilateral knee tear was received on August 17, 2015. The Utilization Review physician determined on August 19, 2015 that magnetic resonance angiogram of the bilateral knees was not medically necessary.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**MRA of bilateral knees:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004.

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

**Decision rationale:** The ACOEM chapter on knee complaints 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 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 patient has history of previous knee surgery and the ODG states MRA is indicated for evaluation of meniscal tear post surgery. The patient has physical exam findings consistent with possible meniscal injury. Therefore, the request is medically necessary.