MAXIMUS Federal Services

Case Number:	CM15-0175370		
Date Assigned:	09/16/2015	Date of Injury:	12/12/2008
Decision Date:	10/19/2015	UR Denial Date:	08/06/2015
Priority:	Standard	Application Received:	09/04/2015

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 65 year old male, who sustained an industrial-work injury on 12-12-08. He reported initial complaints of knee pain. The injured worker was diagnosed as having pain in joint-knee, left knee arthrofibrosis. Treatment to date has included medication, ice, rest, elevation, chiropractic therapy, surgery (knee arthroscopy, total knee replacement), and diagnostics. MRI results were reported on 8-24-10, of left knee that reported complex tear of the posterior and anterior horns of the medial meniscus, severe osteoarthritis of the femorotibial joint and joint effusion. Currently, the injured worker complains of left ankle, left foot, left cervical dorsal, left lumbar, left sacroiliac, lumbar, right lumbar, right sacroiliac, right anterior knee and left anterior knee pain. Pain is rated 7 out of 10 and best at 3 out of 10. There is numbness and tingling right foot, left anterior wrist, left posterior wrist, left anterior hand, and left posterior hand pain occurring approximately 50 percent of the time. There is also stress and anxiety along with insomnia. Per the primary physician's progress report (PR-2) on 7-30-15, exam noted healed post- surgical scar to right knee and left knee. There is palpable tenderness of the left medial joint with crepitus and edema. Left flexion is at 110-130, extension at 0, right flexion at 120, extension at 0, knee extension bilaterally was 4 out of 5. DTR (deep tendon reflexes) are all 2+. Current plan of care includes update imaging studies, diet modification for weight loss, and medication. The Request for Authorization date was 7-30-15 and requested service included bilateral knee CT Scan. The Utilization Review on 8-6-15 denied the scan due to having no documentation to support an acute change in symptoms or red flags, recent trauma, or other concerns per CA MTUS (California Medical Treatment Utilization Schedule) Guidelines, Knee complaints 2004.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Knee CT Scan: Upheld

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 no red flags on exam and no new physiologic deficits since last MRI. There are no planned invasive surgeries. Therefore, the request is not medically necessary.