

Case Number:	CM15-0177559		
Date Assigned:	09/18/2015	Date of Injury:	02/08/2014
Decision Date:	10/21/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	09/09/2015

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: 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 35 year old male, who sustained an industrial injury on 2-08-2014. The injured worker was diagnosed as having other and unspecified derangement of medial meniscus, sprain of lateral collateral ligament of knee, and chondromalacia of patella. Treatment to date has included diagnostics, left knee surgery in 2014, physical therapy, and medications. Currently (7-29-2015), the injured worker complains of symptoms of pain in the neck (rated 6 out of 10), low back (rated 6 out of 10), and bilateral knees (rated 7 out of 10 on left and 8-9 out of 10 on right). He reported that approximately 3 months prior, his left knee gave out, and he fell down stairs, landing on his right knee. He reported that walking increased knee pain and reported temporary relief with rest, ice, and medications. The use of a knee brace was noted for the left, which made him feel "more steady". He reported pain with "first step" on the right. He reported difficulty and pain with activities of daily living and reported "everything" caused pain. He reported that he could stand for 10 minutes before he had to sit down to relieve the pain. Medication use included Norco and Flexeril. Exam of the right knee noted 1+ pain at the medial joint line, medial patellar facet, lateral patellar facet, and 1+ patellar grind. Flexion was 135 degrees and extension full. Strength in the right quadriceps and hamstring was 4 out of 5. X- rays of the bilateral knees were reviewed and were documented as showing "no significant arthritic changes" and "no abnormal ossification or calcification". An impression of right knee compensatory pain after a fall, with popping, catching, clicking, and medial joint line tenderness was noted. He was scheduled to

start physical therapy for both knees. The treatment plan included magnetic resonance imaging of the right knee without contrast to rule out internal derangement, non-certified by Utilization Review on 9-01-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI right knee without contrast: 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 nonacute 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 a history of meniscal injury status post surgery. Most recent exam shows positive patellar grind and joint line tenderness. No instability of joint on exam. Therefore the request is not medically necessary.