MAXIMUS Federal Services

Case Number:	CM14-0198917		
Date Assigned:	12/09/2014	Date of Injury:	03/24/2011
Decision Date:	01/22/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/26/2014

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 56-year-old man with a date of injury of March 24, 2011. The mechanism of injury was not documented in the medical record. The current diagnoses are left knee internal derangement, degenerative joint disease, effusion, tendinitis quadriceps, status post left knee arthroscopy; low back pain with degenerative disc herniation and degenerative disc disease; cervical strain with disc herniation and degenerative disc disease; radiculitis; impingement syndrome left shoulder; left shoulder rotator cuff tendinitis; rule out bilateral wrist carpal tunnel syndrome; bilateral wrist sprain; left ankle sprain, arthrosis; and rule out left ankle impingement syndrome. Pursuant to a pain management progress note dated July 18, 2014, the IW complains of cervical radicular pain and lumbar radicular pain. Pain radiates down both legs. The pain is made better with Diclofenac and Tramadol. Knee complains were not addresses by the provider. Pursuant to a progress note dated October 13, 2014, the IW reports that his symptoms are essentially unchanged. He had x-rays showing some patellofemoral chondromalacia and arthrosis. MRI studies were reviewed which revealed some degenerative changes and internal derangement of the knee. Physical examination of the left knee revealed limited motion. Positive quadriceps atrophy. Significant tenderness of the quadriceps tendon at the insertion to the patella noted. There was positive crepitus, and positive axial compression test. There was pain on full extension. Positive patellofemoral facet tenderness was noted. There is a physical therapy progress note dated February 18, 2013 indicating that the IW had undergone 10 of his 18 approved physical therapy sessions to the left knee. Documentation indicated that the IW was improving. The treating physician is requesting X-ray left knee, MRI left knee, and physical therapy, left knee 3 X 6 (18 sessions). The IW underwent MRI of the left knee on June 7, 2011 with the following impression: Linear mucoid degeneration with body and posterior horn

of the medial meniscus; patellofemoral chondromalacia; mild medial tibiofemoral osteoarthritis. No other significant findings noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of left knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC, Knee and Leg

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Section, MRI

Decision rationale: Pursuant to the Official Disability Guidelines, MRI of the left knee is not medically necessary. The guidelines enumerated indications for magnetic resonance imaging to the knee. They include, but are not limited to, acute trauma to the knee, including significant trauma or if suspect posterior knee dislocation or ligament or cartilage description. See guidelines for additional details. Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended. Soft tissue injuries (meniscal, chondral surface injuries and ligamentous disruption) are best evaluated by MRI. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and findings suggestive of significant pathology. In this case, the injured worker is a 56-year-old man with a date of injury March 24, 2011. An MRI of the left knee was performed June 7, 2011. It showed linear mucoid generation within body and posterior horn of medial meniscus; patellofemoral chondromalacia; mild medial tibia femoral osteoarthritis; and no other significant findings noted. Medical documentation from June 13, 2014 and July 18, 2014 orthopedic progress note (Advance Orthopedic Center page 71) does not contain subjective evidence of knee pain or discomfort, physical examination evidence of knee tenderness or decreased range of motion, the impression does not contain a diagnosis referable to the knee nor is there any plan addressing immediate or future knee workup. There is a physical therapy request two to three times a week for six weeks, however it does not state the areas to be treated. A progress note from October 13 of 2014 indicates "his symptoms are essentially unchanged". X-rays show patella-femoral chondromalacia and arthrosis. MRI studies (2011) showed degenerative changes in internal derangement of the knee) physical examination shows positive warmth, positive quadriceps atrophy negative medial joint line tenderness. The diagnosis indicates left knee internal derangement, degenerative joint disease, effusion, tendinitis quadriceps, status post left knee arthroscopy; low back pain with degenerative disc and disk herniation; cervical strain discrimination; radiculitis; impingement syndrome left shoulder; etc. The documentation indicates the injured worker's symptoms are essentially unchanged from prior documentation. The documentation from 2012 indicates the injured worker underwent physical therapy 13 out of 18 sessions to the left knee. The injured worker was seen by [redacted], Anesthesiology and Pain Medicine who omitted any subjective or objective documentation referencing the affected left knee. As noted above, symptoms remained

unchanged in the October note. In the absence of new clinical symptoms or progressive clinical symptoms, based on the documentation, repeat MRI of the left knee is not medically necessary. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and findings suggestive of significant pathology. There have been no new significant changes in symptoms and clinical findings indicating an MRI is warranted. Consequently, MRI of the left knee is not medically necessary.

Physical therapy for the left knee three times a week for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional improvement measures, Physical Medicine Page(s): 48, 98.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Knee Chapter, Physical Therapy

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy to the left knee three times a week for six weeks is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). The Official Disability Guidelines numerate the specific frequency and duration based on the disease state. In this case, the injured worker in 2012 received 13 out of 18 physical therapy sessions. There is no documentation of objective functional improvement associated with those visits. In this case, the injured worker is a 56-year-old man with a date of injury March 24, 2011. An MRI of the left knee was performed June 7, 2011. It showed linear mucoid generation within body and posterior horn of medial meniscus; patellofemoral chondromalacia; mild medial tibia femoral osteoarthritis; and no other significant findings noted. Medical documentation from June 13, 2014 and July 18, 2014 orthopedic progress note ([redacted] page 71) does not contain subjective evidence of knee pain or discomfort, physical examination evidence of knee tenderness or decreased range of motion, the impression is not contain a diagnosis referable to the knee nor is there any plan addressing immediate or future To the knee. There is a physical therapy request to three times a week for six weeks; however it does not state the areas to be treated. A progress note from October 13 of 2014 indicates "his symptoms are essentially unchanged". X-rays show patella-femoral chondromalacia and arthrosis. MRI studies (2011) showed degenerative changes in internal derangement of the knee) physical examination shows positive warmth, positive quadriceps atrophy negative medial joint line tenderness. The diagnosis indicates left knee internal derangement, degenerative joint disease, effusion, tendinitis quadriceps, status post left knee arthroscopy; low back pain with degenerative disc and disk herniation; cervical strain discrimination and the generative this disease; radiculitis; impingement syndrome left shoulder; etc. The injured worker was seen by [redacted] [redacted] anesthesiology and pain medicine who omitted any documentation referencing the affected left knee. As noted above, symptoms remained unchanged in the October note. In the absence of new clinical symptoms or progressive clinical symptoms, based on the documentation, physical therapy to the left knee three times a week for six weeks is not clinically indicated. Also, there is no objective functional improvement in the documentation to support additional physical

therapy. Consequently, based on the contradictory examinations in the medical record between July 2014 and October 2014, additional physical therapy to the left knee three times a week for six weeks (18 sessions) is not clinically indicated.