

Case Number:	CM15-0188778		
Date Assigned:	09/30/2015	Date of Injury:	06/11/2010
Decision Date:	11/09/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	09/25/2015

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: Emergency 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 is a 65 year old female with an industrial injury dated 06-11-2010. A review of the medical records indicates that the injured worker is undergoing treatment for bilateral knee pain and dysfunction with mechanical symptoms, right knee medial and lateral meniscus tears and left knee medial meniscus tears. In a progress report dated 06-24-2015, the injured worker reported severe pain in the lumbar spine, cervical spine, bilateral knee and right foot. The injured worker also reported moderate pain in the left foot. Bilateral knee exam (06-24-2015) findings were not included in report. According to the progress note dated 08-26-2015, the injured worker reported constant bilateral knee pain with sharp stabbing. The injured worker reported that the prolonged standing and walking increased the pain. The injured worker also reported weakness, popping and clicking. Pain level was 9-10 out of 10 on a visual analog scale (VAS). Objective findings (08-26-2015) revealed stiff gait with limp on the right, swelling in bilateral knee with small effusions, range of motion 0 to 135 degrees on the right, 0 to 140 degrees on the left, tenderness to palpitation in the medial and lateral joint lines and bilateral knees, and positive Mc Murray of bilateral knees. MRI Arthrogram of right knee dated 07-20-2015 revealed "curvilinear signal abnormality within the lateral femoral condyle including the subchondral regions and extending into the distal metaphysis, consistent with avascular necrosis and bone infarct. Moderate chondral thinning within the patellofemoral compartment, mild to moderate chondral thinning in the medial and lateral compartments, small Baker's cyst and postoperative changes of the lateral meniscus, without discrete re-tear" were also noted on MRI. Treatment has included diagnostic studies, prescribed medications, and periodic follow up visits. There was no previous

bilateral x-ray of the knee reports included in exam. There was no documentation of how many visits of physical or aqua therapy included for review. The treatment plan included pain medications, moist heat treatments, bilateral knee wrap, aqua therapy and follow up visit. The treating physician prescribed services for x-rays of the bilateral knees QTY: 2, range of motion testing, and aqua therapy, 2-3 times weekly for 6 weeks, bilateral knees. The utilization review dated 09-14-2015, non-certified x-rays of the bilateral knees QTY: 2, range of motion testing, and aqua therapy, 2-3 times weekly for 6 weeks, bilateral knees.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-rays of the bilateral knees, QTY: 2: 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 requested X-rays of the bilateral knees, QTY: 2, is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 13, Knee Complaints, Special Studies and Diagnostic and Treatment Considerations, pages 341-343, recommend knee x-rays when patient is able to walk without a limp patient had a twisting injury and there is no effusion. The clinical parameters for ordering knee radiographs following trauma in this population are: Joint effusion within 24 hours of direct blow or fall, palpable tenderness over fibular head or patella, inability to walk (four steps) or bear weight immediately or within a week of the trauma, inability to flex knee to 90 degrees. The injured worker has constant bilateral knee pain with sharp stabbing. The injured worker reported that the prolonged standing and walking increased the pain. The injured worker also reported weakness, popping and clicking. Pain level was 9-10 out of 10 on a visual analog scale (VAS). Objective findings (08-26-2015) revealed stiff gait with limp on the right, swelling in bilateral knee with small effusions, range of motion 0 to 135 degrees on the right, 0 to 140 degrees on the left, tenderness to palpitation in the medial and lateral joint lines and bilateral knees, and positive Mc Murray of bilateral knees. MRI Arthrogram of right knee dated 07-20-2015 revealed "curvilinear signal abnormality within the lateral femoral condyle including the subchondral regions and extending into the distal metaphysis, consistent with avascular necrosis and bone infarct. Moderate chondral thinning within the patellofemoral compartment, mild to moderate chondral thinning in the medial and lateral compartments, small Baker's cyst and postoperative changes of the lateral meniscus, without discrete re-tear" were also noted on MRI. Treatment has included diagnostic studies, prescribed medications, and periodic follow up visits. There was no previous bilateral x-ray of the knee reports included in exam; flex knee to 90 degrees. The treating physician has not documented the presence of any of the criteria noted above. The criteria noted above not having been met, X-rays of the bilateral knees, QTY: 2 is not medically necessary.

Range of motion testing: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Low Back Complaints 2004, and Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Stretching & Flexibility.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic (Acute & Chronic), Knee, Acute & Chronic, Flexibility.

Decision rationale: The requested Range of motion testing, is not medically necessary. Chronic Pain Medical Treatment Guidelines, Functional Improvement Measures, page 48, note that such measures are recommended. However, Official Disability Guidelines (ODG), Low Back-Lumbar & Thoracic (Acute & Chronic), Knee, Acute & Chronic, Flexibility, note that computerized range of motion testing not recommended as a primary criteria, but should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or nonexistent and an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical and inexpensive way (p 400). They do not recommend computerized measures of lumbar spine range of motion which can be done with inclinometers, and where the result (range of motion) is of unclear therapeutic value. The injured worker has constant bilateral knee pain with sharp stabbing. The injured worker reported that the prolonged standing and walking increased the pain. The injured worker also reported weakness, popping and clicking. Pain level was 9-10 out of 10 on a visual analog scale (VAS). Objective findings (08-26-2015) revealed stiff gait with limp on the right, swelling in bilateral knee with small effusions, range of motion 0 to 135 degrees on the right, 0 to 140 degrees on the left, tenderness to palpitation in the medial and lateral joint lines and bilateral knees, and positive Mc Murray of bilateral knees. MRI Arthrogram of right knee dated 07-20-2015 revealed "curvilinear signal abnormality within the lateral femoral condyle including the subchondral regions and extending into the distal metaphysis, consistent with avascular necrosis and bone infarct. Moderate chondral thinning within the patellofemoral compartment, mild to moderate chondral thinning in the medial and lateral compartments, small Baker's cyst and postoperative changes of the lateral meniscus, without discrete re-tear" were also noted on MRI. Treatment has included diagnostic studies, prescribed medications, and periodic follow up visits. There was no previous bilateral x-ray of the knee reports included in exam, flex knee to 90 degrees. The treating physician has not documented exceptional circumstances to establish the medical necessity for this testing as an outlier to referenced guideline negative recommendations. The criteria noted above not having been met, Range of motion testing is not medically necessary.

Aqua therapy, 2-3 times weekly for 6 weeks, bilateral knees: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Aquatic therapy.

Decision rationale: The requested Aqua therapy, 2-3 times weekly for 6 weeks, bilateral knees, is not medically necessary. Chronic Pain Medical Treatment Guidelines, Aquatic Therapy, Page 22, note that aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. The injured worker has constant bilateral knee pain with sharp stabbing. The injured worker reported that the prolonged standing and walking increased the pain. The injured worker also reported weakness, popping and clicking. Pain level was 9-10 out of 10 on a visual analog scale (VAS). Objective findings (08-26-2015) revealed stiff gait with limp on the right, swelling in bilateral knee with small effusions, range of motion 0 to 135 degrees on the right, 0 to 140 degrees on the left, tenderness to palpation in the medial and lateral joint lines and bilateral knees, and positive Mc Murray of bilateral knees. MRI Arthrogram of right knee dated 07-20-2015 revealed "curvilinear signal abnormality within the lateral femoral condyle including the subchondral regions and extending into the distal metaphysis, consistent with avascular necrosis and bone infarct. Moderate chondral thinning within the patellofemoral compartment, mild to moderate chondral thinning in the medial and lateral compartments, small Baker's cyst and postoperative changes of the lateral meniscus, without discrete re-tear" were also noted on MRI. Treatment has included diagnostic studies, prescribed medications, and periodic follow up visits. There was no previous bilateral x-ray of the knee reports included in exam, flex knee to 90 degrees. The treating physician has not documented failed land-based therapy nor the patient's inability to tolerate a gravity-resisted therapy program. The treating physician has not documented objective evidence of derived functional benefit from completed aquatic therapy sessions, such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention. The criteria noted above not having been met, Aqua therapy, 2-3 times weekly for 6 weeks, bilateral knees is not medically necessary.