

Case Number:	CM15-0191039		
Date Assigned:	10/05/2015	Date of Injury:	07/02/2005
Decision Date:	11/10/2015	UR Denial Date:	09/23/2015
Priority:	Standard	Application Received:	09/29/2015

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: Physical Medicine & Rehabilitation

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 52 year old female, who sustained an industrial injury on 7-2-2005. The injured worker is undergoing treatment for bilateral arthroscopic knee surgery; torn lateral meniscus and chondromalacia (09-2013) and compensatory lumbosacral spine strain. Exam dated 2-25-2015 indicates the injured worker's on 2-24-2015 her left knee popped and she began to experience severe pain. Physical exam noted left knee tenderness to palpation with restricted range of motion (ROM) with crepitus. Medical records dated 8-31-2015 indicate the injured worker complains of constant sharp bilateral knee pain rated 8 out of 10. The treating physician indicates knee weakness and occasionally her knees give way resulting in falls. Physical exam dated 8-31-2015 notes antalgic gait, bilateral knee tenderness to palpation and decreased range of motion (ROM). Treatment to date has included surgery, physical therapy and medication. The original utilization review dated 9-23-2015 indicates the request for magnetic resonance imaging (MRI) arthrogram for the left knee is non-certified and physical therapy for the left knee 2X4 is modified.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (Magnetic Resonance Imaging) Arthrogram for the left knee: 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 patient has unchanged symptom complaints and clinical findings for this chronic injury without clinical change, red-flag conditions or functional deterioration since prior MRI and arthroscopic surgery of the knee performed. Besides continuous intermittent pain complaints with limited range of motion, exam is without neurological deficits, report of limitations, acute flare-up or new injuries. There is no report of failed conservative trial or limitations with ADLs that would support for an Arthrogram when there is no x-ray of the knee for review. Guidelines states that 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). The guideline criteria have not been met as guidelines recommend Knee Arthrogram for suspected residual or recurrent tear, for meniscal repair and greater than 25% meniscal resection, not identified here. The MRI (Magnetic Resonance Imaging) Arthrogram for the left knee is not medically necessary and appropriate.

Physical therapy for the left knee 2 times a week for 4 weeks: 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): Physical Medicine.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic 2005 injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy for the left knee 2 times a week for 4 weeks is not medically necessary and appropriate.