

<b>Case Number:</b>	CM15-0211820		
<b>Date Assigned:</b>	10/29/2015	<b>Date of Injury:</b>	03/26/2014
<b>Decision Date:</b>	12/11/2015	<b>UR Denial Date:</b>	10/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2015

### 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, Oregon, Washington  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 53 year old female, who sustained an industrial injury on 3-26-2014. The injured worker was diagnosed as having increased intrameniscal signal extending toward the articular surface in the anterior horn of the left medial meniscus, consistent with anterior horn medial meniscus tear (per magnetic resonance imaging 6-2014), status post left knee unsuccessful arthroscopy 12-10-2014, left knee pain, low back pain, mild chondromalacia of patella and degenerative changes, superolateral facet (per right knee magnetic resonance imaging 6-2015), subcutaneous hematoma anterior to the inferior enthesis of the ligamentum patellae, with extensive periosteous and periligamentous soft tissue edema (per right knee magnetic resonance imaging 6-2015), intrasubstance degeneration of medial meniscus, particularly severe at the posterior root zone (per right knee magnetic resonance imaging 6-2015), and small joint effusion (per right knee magnetic resonance imaging 6-2015). Treatment to date has included diagnostics, left knee surgery 12-2014, and medications. On 9-16-2015, the injured worker complains of left knee pain, rated 5 out of 10 (rated 2 out of 10 on 5-11-2015), "significantly increased from the value given on her last visit". She reported increase in activity level recently, possibly accounting for the elevation in subjective pain. Exam of the bilateral knees noted active extension to 0 degrees and flexion to 90 degrees, with passive flexion to 100 degrees. She was moderately tender to palpation over the medial and lateral tibiofemoral joint spaces, there was no increased laxity as valgus, and varus stress was applied. The treating physician documented that she had not undergone any conservative measures to the right knee. Work status was modified. Current medication regimen was not noted, but included Ibuprofen. Magnetic

resonance imaging of the left knee (3-25-2015) noted no evidence of ligamentous injury or meniscal tear, mild to moderate degenerative change at the medial compartment of the patellofemoral joint, thin fissure at the articular cartilage of the lateral patellar facet, and mild to moderate edematous change in the region of the pes anserinus bursa. The treatment plan included follow-up in 6 weeks for re-evaluation, physical therapy for the right knee, left knee arthroscopy with manipulation under general anesthesia, and medication. On 10-12-2015 Utilization Review non-certified a request for left knee arthroscopy with manipulation under general anesthesia, physical therapy for the right knee, 2x3, and follow-up visit in 6 weeks for re-evaluation.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Physical Therapy On The Right Knee, 2 Times A Week For 3 Weeks (Total Of 6 Sessions): Overturned**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) leg & ankle / Physical medicine treatment.

**Decision rationale:** In this case an MRI of the right knee (in this case the non-operative knee) showed mild chondromalacia of patella and degenerative changes of the superolateral facet (right knee MRI from 6-2015). Per ODG (leg & ankle / Physical medicine treatment) guidelines, physical therapy for the knee is: "Recommended. Positive limited evidence. As with any treatment, if there is no improvement after 2-3 weeks the protocol may be modified or re-evaluated." ODG guidelines define the recommendation for the diagnosis of chondromalacia of patella as being "Medical treatment: 9 visits over 8 weeks". In this case the request for 6 PT sessions is within the ODG guidelines and thus the recommendation is medically necessary.

#### **Left Knee Arthroscopy With Manipulative Under General Anesthesia Per [REDACTED]: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Manipulation under anesthesia & Meniscectomy.

**Decision rationale:** CAMTUS/ACOEM Chapter 13 Knee Complaints, pages 344-345, states regarding meniscus tears, Arthroscopic partial meniscectomy usually has a high success rate for cases in which there is clear evidence of a meniscus tear symptoms other than simply pain (locking, popping, giving way, recurrent effusion). According to ODG Knee and Leg section, Meniscectomy section, states indications for arthroscopy and meniscectomy include attempt at

physical therapy and subjective clinical findings, which correlate with objective examination and MRI. In this case the exam notes from 9/16/15 do not demonstrate evidence of adequate course of physical therapy or other conservative measures. In addition there is lack of evidence in the cited records of meniscal symptoms such as locking, popping, giving way or recurrent effusion. Therefore the determination is for non-certification. CA MTUS/ACOEM Guidelines are silent on the issue of manipulation under anesthesia. Per the ODG Knee and Leg, Manipulation under anesthesia, Recommended as an option for treatment of arthrofibrosis (an inflammatory condition that causes decreased motion) and/or after total knee arthroplasty. MUA of the knee should be attempted only after a trial (six weeks or more) of conservative treatment (exercise, physical therapy and joint injections) have failed to restore range of motion and relieve pain, and a single treatment session would then be recommended, not serial treatment sessions of the same bone/joint subsequently over a period of time. Following total knee arthroplasty, some patients who fail to achieve >90 degrees of flexion in the early perioperative period, or after six weeks, may be considered candidates for manipulation of the knee under anesthesia. In this case there is insufficient evidence of failure of conservative management in the notes submitted from 9/16/15. In addition the claimant has greater than 90 degrees of flexion. Until a conservative course of management has been properly documented, the determination is not medically necessary.

#### **Follow-Up Visit In 6 Week For Re-Evaluation X 1: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC.

**Decision rationale:** CA MTUS is silent on the subject of office visits. The ODG-TWC recommends follow-up as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. In this case the follow-up visit is medically necessary in order to ascertain the response from the physical therapy for the nonoperative treatment of the right knee.