

Case Number:	CM15-0068380		
Date Assigned:	04/16/2015	Date of Injury:	07/15/2012
Decision Date:	05/20/2015	UR Denial Date:	04/03/2015
Priority:	Standard	Application Received:	04/10/2015

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: Minnesota, Florida

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:

This 36 year old female sustained an industrial injury on 7/15/12. She subsequently reported bilateral knee pain. Diagnoses include intra articular ganglion bilateral knees, chondromalacia patellofemoral joint bilateral knee and intra articular adhesions right knee. Treatments to date have included x-rays, MRIs, physical therapy, modified work duty, injections, acupuncture, surgery and prescription pain medications. The injured worker continues to experience upper back, lower back and right knee pain. A request for Repeat MRI of the right knee 3T scanner, Physical therapy x6 for right knee and Arthroscopic lateral release of the right knee was made by the treating physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat MRI of the right knee 3T scanner: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Knee, Topic: Magnetic Resonance Imaging scan.

Decision rationale: With regard to the request for a repeat MRI scan, ODG guidelines indicate necessity for magnetic resonance imaging in the presence of acute trauma to the knee, nontraumatic knee pain with the x-rays being nondiagnostic. Repeat MRI scans post surgical if need to assess knee cartilage repair tissue. In this case, the symptoms have not changed and the MRI scan shows a ganglion cyst of the anterior cruciate ligament but is otherwise negative. As such, a repeat MRI is not supported by guidelines and not medically necessary.

Physical therapy x6 for right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: With respect to the request for physical therapy x6, the California MTUS chronic pain guidelines indicate active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete is specific exercise or task. This form of therapy may require supervision from a therapist or medical provider. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The injured worker has completed the postoperative physical therapy and is familiar with the active exercise program. There is no reason given why she cannot continue the same treatment at home. As such, the request for 6 additional sessions of physical therapy is not supported and not medically necessary.

Arthroscopic lateral release of the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 345.

Decision rationale: With regard to the request for arthroscopy with a lateral retinacular release, the medical records indicate that a lateral retinacular release was performed in the past and subsequent x-rays including merchant's views did not show any lateral subluxation or lateral tilting of the patella. As such, a repeat lateral retinacular release is not indicated. However, a diagnostic arthroscopy is appropriate to determine the pain source and need for additional treatment. A lateral capsular release has also been certified, if found necessary at the time of surgery. California MTUS guidelines indicate a lateral arthroscopic release may be indicated in

cases of recurrent subluxation of the patella. The documentation provided does not indicate the presence of recurrent subluxation of the patella. As such, the request for a lateral retinacular release is not supported at this time, and is not medically necessary.