



**CLAIMS EVAL**

*Utilization Review and  
Peer Review Services*

Notice of Independent Review Decision-WC

**DATE OF REVIEW: 12-27-10**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Outpatient additional six sessions of individual psychotherapy as it relates to the bilateral knees

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Psychologist

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

MD., the claimant reported he was restraining a and both knees hit the floor. The claimant works as a and he was restraining someone when he hit both knees upon the concrete floor this am. The claimant has pain in both knees with the right worse than the left. Physical Examination: Bilateral Knees: The knee joint is stable. Knee shows no deformity. No knee effusion. No erythema. No giving way; cannot actively extend the knee against gravity. Decreased Range of Motion: All directions: With pain tenderness diffusely. Assessment: Knee contusion, bilateral. Plan: The claimant was prescribed Ibuprofen and Cyclobenzaprine. Physical Therapy from 2-6-08 through 2-8-08 (2 visits)

2-7-08 Statement Accepted Fact: The carrier is disputing entitlement of all medical and indemnity benefits for conditions, diagnosis, and symptoms for diabetes and high blood pressure because: the compensable injury is limited to contusion to both knees. All other injuries, conditions, diagnosis and-or symptoms related to another part of the body are denied as not resulting from the accident. The carrier will continue to pay reasonable and necessary medical treatment related to a contusion of both knees.

2-16-08 DO., the claimant was in a situation on xx/xx/xx where he was restraining an individual and he came down hard on both of his knees. He was evaluated by the physician at and was told he has some bone contusion and week ligaments in his knees. The claimant presents today for evaluation of both knees and recommended therapy approaches. He says that his pain is relatively hard on him. He did some physical therapy, which was basically on an exercise bicycle, which caused him some increase in pain. Also, in the course of the past couple of weeks, he has had problems, especially when he drives in a small vehicle; his knee tends to bother him as well. He experiences increasing pain and he has to stop and stretch his knees out also. He has no significant swelling that he knows of, just pain. He states that he didn't really get a clear understanding of what's going on with his knees, but he was referred here. Physical Examination: Evaluation of the knees on general inspection reveals no significant joint effusions or sign of infection. There is some scarring noted from past surgery as a teenager, where he apparently sustained a tibia fracture. He said that he had a screw in place, but there is no sign of infection. Palpation reveals no palpable fluid wave. Discomfort upon manipulation and mild crepitus noted upon flexion and extension passively at the knees bilaterally. There is some joint line tenderness bilaterally as well. There is also some laxity noted on various stress tests of both knees with some discomfort as well. He says also pointing and palpating in the region of the lateral collateral ligaments has some discomfort there. Impression: Knee pain, lateral collateral ligament laxity bilaterally. Plan: No work for 30 days. Physical therapy aggressively for quad-strengthening, ligament stability, and range of motion. The claimant was prescribed Naprosyn and Tramadol. The evaluator has also recommended patella stabilizing braces for comfort and support while he is completing

therapy. See him back in the office in a month. See how he is doing at that point. If there is no significant improvement, the evaluator will pursue an orthopedic consultation or recommend MRI's at that time.

2-29-08 M.Ed., the claimant presents for a Psychological Evaluation. Diagnosis: Axis I: Adjustment Disorder, with mixed anxiety and depressed mood, secondary to the work injury. Axis II: No diagnosis. Axis III: Right knee sprain-strain, secondary to the work injury. Axis IV: Primary support group and occupational. Axis V: GAF =75 (current). Estimated pre-injury GAF = 95+. Plan: The claimant should receive immediate authorization for participation in a low level of individual psychotherapy for a minimum of 6 weeks. Results of the Beck Depression Inventory-II (BDI-II) and the Beck Anxiety Inventory (BAI) reveal the following: The claimant scored an 11 on the BDI-II, indicative of minimal depression. He scored a 6 on the BAI, indicative of minimal anxiety. Becks appear incongruent with clinical observation and subjective reports.

3-10-08 DO., the claimant states that he is doing better. He has not started physical therapy yet. His knees still pop and grind when he walks and when he gets up from a sitting position. He wishes to go back to work. Physical Examination:

He has decreased range of motion on flexion and extension. He has some crepitus. He has a positive Apley's, positive Smiley's, and positive patellar grind. Mild knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, lateral collateral ligament strain bilaterally, internal derangement of the bilateral knees. Plan: Will release to full duty without restriction on 3-18-08. Proceed with physical therapy. The evaluator will order an MRI of both knees to rule out internal derangement. Continue his medication for pain. Follow-up in the office in a month.

3-14-08 MRI of the left knee without contrast performed by MD., showed increased T2 signal in the quadriceps fat pad with adjacent bone marrow edema in the superior pole of the patella is suspicious for quadriceps fat pad syndrome which can be a source of anterior knee pain. Mild mucoid degeneration of the anterior cruciate ligament without definite tear. MRI of the right knee without contrast showed complex tear of the medial meniscus posterior horn with parameniscal cyst. Degenerative change in the lateral compartment with full thickness fissuring and subchondral edema in the lateral tibial plateau and intra-articular osteophyte along the lateral femoral condyle. Attenuated anterior cruciate ligament with mild mucoid degeneration.

3-17-08, DO., the claimant wishes to be on light duty. He went back to work on full duty on 3-11-08 and he is unable to perform his full duty work. Physical Examination: He has decreased range of motion in both knees on flexion and extension. He has bilateral knee effusion. He had MRI's done today, but results are pending this dictation.

Impression: Bilateral knee effusion, bilateral knee sprain-strain, lateral collateral ligament laxity bilaterally, internal derangement of the bilateral knees. Plan: He will be placed on light duty restrictions. Continue physical therapy. Await MRI reports. Continue his Tramadol and Naprosyn. The claimant was prescribed Darvocet N. Follow-up in the office in a week. Obtain an orthopedic consultation at that time.

3-24-08 DO., the claimant returned for follow-up. Physical Examination: He has decreased range of motion on flexion and extension. He has some crepitus. He has a positive Apley's, positive Smiley's, and positive patellar grind. Mild knee effusion. Impression: Bilateral knee effusion, bilateral knee sprain-strain, lateral collateral ligament laxity bilaterally, internal derangement of the bilateral knees. Plan: Continue

light duty. Proceed with physical therapy. Orthopedic consultation as soon as possible. Continue his knee braces. Continue his anti-inflammatory medication. Follow-up in one month.

Physical Therapy from 3-26-08 through 4-28-08 (12 visits)

4-5-08 DO., the claimant has not seen the orthopedic specialist. He states that he is not able to perform his job duties secondary to his pain.

Physical Examination: He has decreased range of motion on flexion and extension. He has some crepitus. He has a positive Apley's, positive Smiley's, and positive patellar grind. Mild knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, lateral collateral ligament strain bilaterally, internal derangement of the bilateral knees. Plan: No work for 30 days.

Continue with physical therapy. Await orthopedic consultation as soon as possible. Continue his knee braces. Continue his medication.

4-10-08 Statement Accepted Fact: The carrier is disputing entitlement of medical treatment and disability benefits arising from quadriceps fat pad syndrome and degenerative conditions in the left and right knees. The carrier accepts that the compensable injury extends to and includes a bilateral knee injury sustained on xx/xx/xx at work in which the claimant fell and injured both knees. The carrier disputes that the compensable injury extends to and includes quadriceps fat pad syndrome and mucoid degeneration of the ACL in the left knee and degenerative and cystic changes in the right knee. These are ordinary diseases of life to which the general public is exposed outside of employment. There is no causal connection between these conditions and the compensable xx/xx/xx work injury.

4-11-08 MD., the claimant complains of bilateral knee pain. Today, the right knee pain is 5 out of 10. It is an intermittent dull aching pain that increases with weight bearing. He notes positive popping and instability, locking and catching of the joint. Left knee pain is 6 out of 10. It is a dull aching pain that increases with weight bearing. He notes popping, locking, catching and instability. Physical Examination: Right knee: Exam of the knee shows skin is normal without any discoloration, redness or warmth. No effusion was noted. The claimant has range of motion from 10 to 95 degrees. Positive patellofemoral crepitus throughout range of motion. Medial and lateral joint line pain. Positive tenderness to palpation on the superior and inferior aspects of the patellar tendon. Positive locking and catching of the joint with flexion and extension actively noted in the office. Patella tracking is unremarkable and no tilting is noted. There is a negative grinding test and negative apprehension test. The knee is normal to varus and valgus stress testing, negative Lachman's test, negative anterior and posterior drawers, negative pivot-shift. Positive McMurray's test. Positive Apley's test. Distal neurovascular status remains intact. Positive instability. Left knee: Exam of the knee shows skin is normal without any discoloration, redness or warmth. No effusion was noted. The claimant has range of motion from 5 to 115 degrees. Positive patellofemoral crepitus throughout range of motion. Medial and lateral joint line pain. Positive tenderness to palpation on the superior and inferior aspects of the patellar tendon. Patella tracking is unremarkable and no tilting is noted. There is a negative grinding test and negative apprehension test. The knee is normal to varus and valgus stress testing, negative Lachman's test, negative anterior and posterior drawers, negative pivot-shift. Positive McMurray's test. Positive Apley's test. Distal neurovascular status remains intact. Positive instability. Impression: Right knee meniscus tear medial versus lateral,

chondromalacia patella, potential for loose body formation, synovial hypertrophy, disruption of anterior cruciate ligament and right knee pain, left knee clinically medial versus lateral meniscus tear, chondromalacia patella, potential for loose body formation and synovial hypertrophy. Plan: The claimant was prescribed Celebrex, Darvocet and Medrol Dosepack. Recommended physical therapy. Reassess in three weeks or sooner if needed. If he is still having pain in the same distribution and of the same magnitude, the evaluator may consider surgical correction of the right knee. The claimant was cautioned that the prescribed medication (NSAIDs) may cause GI upset, nausea, vomiting, hematemesis, and blood in stool or melena.

4-21-08 Statement Accepted Fact: The carrier is disputing entitlement of all medical and indemnity for the bilateral chondromalacia of patellas of the knees because: This condition is an ordinary disease of life to which the general public is exposed to outside of their employment. The compensable injury is limited to a bilateral knee sprain only. No other condition naturally resulted from or was affected by the original accident. All other conditions related to another body parts are denied.

4-23-08 DO., performed a Designated Doctor Evaluation. He certified that the claimant had not reached MMI and estimated 7-23-08 as the date of MMI. The claimant states he is scheduled for a surgical consultation in 1 week. He needs a surgical consultation and surgery for the meniscus tear if the orthopedic surgeon believes it is necessary. If no surgery, then the claimant will need a designated doctor examination for MMI-IR in 1 month. If the claimant has surgery, he will need a designated doctor examination for MMI-IR 2 months after surgery. DWC-73: The claimant was returned to work from 4-23-08 through 7-23-08 with restrictions.

5-2-08 MD., the claimant returned for follow-up visit. The claimant is a known diabetic. Physical therapy and medication have failed to remedy his pain. The evaluator will request surgical correction for the right knee. Impression: Right knee meniscus tear medial versus lateral, chondromalacia patella, potential for loose body formation, synovial hypertrophy, disruption of anterior cruciate ligament and right knee pain, left knee clinically medial versus lateral meniscus tear, chondromalacia patella, potential for loose body formation and synovial hypertrophy. Plan: The claimant is prescribed Celebrex and Ultracet. Secondary to continued conservative treatment involving physical therapy and medications, the evaluator recommend anterior cruciate ligament repair, medial and lateral meniscectomy, and removal of loose body or synovectomy at. Pros and cons of surgery were discussed at greater length including but not limited to infection, wound complication, stiffness, post- traumatic arthritic changes, need for future surgery or surgeries, neurovascular or musculotendinous complications and prolonged rehab. No guarantees about the results or complications given.

5-19-08 DO., the claimant continues to have some discomfort in his left lower extremity, especially in his knee. He has an appointment this month with the surgeons. He is pending surgical repair of his ACL. Physical Examination: He has decreased range of motion on flexion and extension. He has some crepitus. He has a positive Apley's, positive Smiley's, and positive patellar grind. Mild knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, lateral collateral ligament strain bilaterally, internal derangement of the bilateral knees. Plan: Place him on light duty with multiple work restrictions. Continue with physical therapy. Continue to follow up for surgical evaluations. Continue Tramadol and Naprosyn.

5-29-08 MD., preoperative diagnosis: Right knee medial and lateral meniscus tear and postoperative diagnosis: Right knee medial and lateral meniscus tear, partial tear, anterior cruciate ligament, loose body, internal derangement-synovial hypertrophy. Procedure: Right knee arthroscopy, medial and lateral meniscectomy, partial. Tricoartmental synovectomy and removal of the loose body.

5-30-08 MD., the claimant returned for follow-up. During right knee surgery, ACL appeared to be nearly if not completely torn as per intra-operative pictures. Please see pictures for details. Right knee pain is 7 out of 10. Physical Examination: Right knee: Bulky dressing in place after surgery which was removed. Two trochar sites at the medial and lateral aspects of the knee with stitches in place for hemostasis. There is no serosanguineous or pus-like drainage. No fluid emitting from the trochar sites. There is only minimal swelling. There is no ecchymosis. No gross signs of infection. Range of motion is severely limited secondary to pain in the postoperative setting. Impression: Status post surgery on 5-29-08 for right knee meniscus tear medial and lateral, right knee chondromalacia patella, potential for loose body formation, synovial hypertrophy, disruption of anterior cruciate ligament and right knee pain, left knee clinically medial versus lateral meniscus tear, chondromalacia patella, potential for loose body formation and synovial hypertrophy. Plan: Continue to recommend physical therapy through Dr. to begin 6-3-08. Discontinue Ace wrap dressing and, upon arriving home today, should transition to hinged knee brace which he currently has in his possession. Continue Celebrex, Vicodin and Lunesta.

Physical Therapy from 6-9-08 through 7-11-08 (12 visits)

6-12-08 MD., the claimant returned for follow-up visits. Based on operative photos, one can clearly see complete decimation of the anterior cruciate ligament with only slight remnant remaining and fragmentation of the anterior cruciate ligament. Physical Examination: Right knee: Two sutures in place for hemostasis which were removed showing well healed portal sites. No serosanguineous or pus-like drainage or gross signs of infection. He is tender at the well healed trocar sites. Positive McMurray's. Positive Apley's. He has pain to varus and valgus stressing. He has some slight medial and lateral joint line pain. He walks with minimal limp without any assistance of crutches, wheelchair or walker. Neurovascularly intact. Mild patellofemoral crepitus throughout range of motion. Range of motion is limited today at 8 to 105 degrees. Impression: Status post surgery on 5-29-08 for right knee meniscus tear medial and lateral, right knee chondromalacia patella, potential for loose body formation, synovial hypertrophy, disruption of anterior cruciate ligament and right knee pain, left knee clinically medial versus lateral meniscus tear, chondromalacia patella, potential for loose body formation and synovial hypertrophy. Plan: The claimant was prescribed Celebrex and Hydrocodone. Continue physical therapy. Regarding the claimant's litigation date for compensability of the anterior cruciate ligament, the mechanism of this claimant's injury is that he states he was when he fell to the ground on both knees. This mechanism of injury could cause an excessive anterior or posterior force or excessive rotation force which could potentially cause disruption or full thickness tear of the anterior cruciate ligament. MRI and surgery verifies disruption of the ACL and

therefore the evaluator feel it should be treated under his workers compensation case. The claimant was informed to follow-up with his treating doctor regarding compensability of the ACL.

6-16-08 DO., the claimant had surgery on his knee for medial meniscus tear on 5-27-08. He continues to have some edema of the knee and some discomfort. Otherwise, he is active in physical therapy. Physical Examination: He has decreased range of motion on flexion and extension. He has some crepitus. He has a positive Apley's, positive Smiley's, and positive patellar grind. Mild knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, lateral collateral ligament strain bilaterally, internal derangement of the bilateral knees. Plan: Continue no work status, status post surgery. Continue with physical therapy. Continue to follow up with his surgeons. Continue Tramadol and Naprosyn, for which he has multiple refills. Follow-up in the office in a month.

7-7-08 DO., the claimant continues to have discomfort in his left knee. He has some swelling. He is having difficulty sleeping. He has a lot of anger with the system and is pending surgical repair of his ACL which is still in the courts. He is asking to be referred to a psychologist. This is an appropriate request. Physical Examination: He has decreased range of motion on flexion and extension. He has some crepitus. He has a positive Apley's, positive Smiley's, and positive patellar grind. Mild knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, lateral collateral ligament strain bilaterally, internal derangement of the bilateral knees. Plan: Continue his light duty status with multiple work restrictions. Continue with physical therapy. Continue to follow up for surgical evaluations. He will continue to take his Tramadol and Naprosyn for which he has multiple refills.

8-6-08 Statement Accepted Fact: The carrier is disputing entitlement of medical treatment and disability benefits relating to depression and anxiety because: It is the carrier's position that these conditions are incidental findings that did not directly result from the compensable x-x-xx work injury. The carrier accepts that the compensable injury extends to a right knee medial meniscus tear and left knee contusion only. The carrier disputes that the injury extends to include depression or anxiety.

8-6-08 DO., the claimant is still having significant pain. He had surgery on right knee back in May for an ACL tear and complex medial meniscus tear. He still has pain in his left knee. The orthopedic surgeon is requesting an MRI of the left knee with contrast. Physical Examination: Decreased range of motion in both knees on flexion and extension. He has a positive Apley's, positive Smiley's and positive patellar grind bilaterally with bilateral knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, lateral collateral ligament strain bilaterally, internal derangement of the bilateral knees. Plan: No work for 30 days. No light duty available at his work. Continue physical therapy. Will consider the work hardening program. Follow up orthopedic consultation as soon as

possible. MRI of the left knee with contrast. The claimant was prescribed Tramadol, Naprosyn and Elavil. Follow-up in a month.

8-7-08 MS., the claimant presents for a Psychological Evaluation. Diagnosis: Axis I: Major Depressive Disorder, single episode, moderate, secondary to the work injury. Axis II: No diagnosis. Axis III: Injury to both knees-see medical records. Axis IV: Primary support group, Economic, and Occupational issues. Axis V: GAF = 60 (current)

Estimated pre-injury GAF = 85+. The claimant should receive immediate authorization for participation in a low level of individual. Results of the Beck Depression Inventory-II (BDI-II) and the Beck Anxiety Inventory (BAI) reveal the following: The claimant scored a 24 on the BDI-II, indicative of moderate depression. He scored a 22 on the BAI, indicative of moderate anxiety.

9-5-08 MD., the claimant returned for follow-up visit. He has a court hearing set hopefully within the next six weeks. Regarding the left knee, the claimant has repeat left knee MRI scheduled this coming Monday, 9-8-08. He was advised to fax the report to our office for immediate comment. Since he has failed conservative treatment in regards to his left knee, the evaluator will be requesting surgical intervention. With postoperative changes in the right knee, the evaluator will be requesting Visco-supplementation. Impression: Status post surgery on 5-29-08 for right knee meniscus tear medial and lateral, right knee chondromalacia patella, potential for loose body formation, synovial hypertrophy, disruption of anterior cruciate ligament and right knee pain, left knee clinically medial versus lateral meniscus tear, chondromalacia patella, potential for loose body formation and synovial hypertrophy. Plan: Continue to recommend physical therapy through Dr. He states all therapy is being denied. Remain as active as possible at home using braces as necessary for intractable or increased pain. Discontinue bracing when pain is controlled to maintain strength and toning of bilateral knees and lower extremities. The claimant was prescribed Celebrex and Hyalgan. Due to positive pain and symptomatology and physical exam findings, the evaluator recommend left knee medial and lateral meniscectomy, chondroplasty, and removal of loose body or synovectomy at Medical Center. Pros and cons of surgery were discussed at greater length including but not limited to infection, wound complication, stiffness, post-traumatic arthritic changes, need for future surgery or surgeries, neurovascular or musculotendinous complications and prolonged rehab. No guarantees about the results or complications given.

9-8-08 MRI of the left knee without contrast performed by MD., showed stable MRI of the knee. Increased T2 signal within the quadriceps fat pad and adjacent bone marrow edema-cyst formation in the superior pole of the patella may be indicative of quadriceps fat pad syndrome. Mild mucoid degeneration of the anterior cruciate ligament.

Psychotherapy from 9-9-08 through 10-30-08 (6 sessions)

9-19-08 MD., the claimant returned for follow-up visit. Bilateral knee pain is 3 out of 10. Visco-supplementation injection series which was prescribed on 9-5-08 has been approved by the carrier for right knee injections times three. Per Irene at the insurance

company, this procedure is not related to the disputes on file. Physical Examination: Right knee: Two well healed portal sites medial and lateral aspects of the joint line. No serosanguineous or pus-like drainage or gross signs of infection. He is not tender to palpation along the well healed trocar sites. Positive McMurray's. Positive Apley's. He has pain to varus and valgus stressing. He has medial and lateral joint line pain. He walks with slight limp without any assistance of crutches, wheelchair or walker. He is wearing a right knee brace. Neurovascularly intact. Mild patellofemoral crepitus throughout range of motion. Range of motion is limited today at 4 to 98 degrees. Left knee: Exam of the knee shows skin is normal without any discoloration, redness or warmth. No effusion was noted. The claimant has range of motion from 2 to 112 degrees. Positive patellofemoral crepitus throughout range of motion. Medial and lateral joint line pain. Positive tenderness to palpation on the superior and inferior aspects of the patellar tendon. Patella tracking is unremarkable and no tilting is noted. There is a negative grinding test and negative apprehension test. The knee is normal to varus and valgus stress testing, negative Lachman's test, negative anterior and posterior drawers, negative pivot-shift. Positive McMurray's test. Positive Apley's test. Distal neurovascular status remains intact. Positive instability. Impression: Status post surgery on 5-29-08 for right knee meniscus tear medial and lateral, right knee chondromalacia patella, potential for loose body formation, synovial hypertrophy, disruption of anterior cruciate ligament and right knee pain, left knee clinically medial versus lateral meniscus tear, chondromalacia patella, potential for loose body formation and synovial hypertrophy. Plan: Proceed with Euflexxa injection #1 to the right knee. Other recommendations same as 9-5-08. Reassess in one week.

9-23-08 MD., performed a Peer Review. It was his opinion that the competent, objective and independently confirmable medical evidence does not support that any of the intra-articular pathology is a function of this injury. It is understood that the meniscal tear was accepted, however, the MRI report notes that there is a multi-loculated cystic lesion and thinning of the medial compartment cartilage. However, the fall was onto both knees. There was no mention of any rotation component until Dr. suggested it some months later. Please note that the attenuation of the ACL with mucoid degeneration is present in both knees. That makes this an ordinary disease of life. In addition, as noted in the citations below (and only a sample number are listed) this mucinoid degenerative change is a common ordinary disease of life. Moreover, given the extensive degenerative changes within the knee, the lack of instability noted on physical examination and that there was no joint effusion present on MRI objectifies that the changes noted are not acutely traumatic or a function of this reported mechanism of injury. As noted the degenerative process is identified in both knees. The imaging studies completed shortly after the date of injury note no effusion or evidence of an acute event. The changes to the normal bony architecture, the ligaments and the meniscus are degenerative. The surgical removal of the synovitis is evidence of the long-standing degenerative process. The changes noted are nothing more than ordinary disease of life maladies. The Designated Doctor was correct in noting a knee contusion. One does not doubt the pathology, only the specific cause and the absolute lack of any objective data to attribute this to an acute trauma. When considering the reported mechanism of injury, the initial complaints and findings on physical examination

tempered with the assessments of the MRI studies, 100%. This injured claimant is morbidly obese (BMI-31) and has significant degenerative changes in both knees. The fall forward would take the stress off the ACL's and not stretch (or attenuate) these structures. These issues should be addressed as an ordinary disease of life and not as part of the compensable event.

9-26-08 MD., procedure performed: Euflexxa injection #1 to the right knee.

10-3-08 MD., procedure performed: Euflexxa injection #1 to the right knee.

10-6-08 DO., the claimant is still having some significant pain in his knees. He has swelling on the lateral aspect of the right knee. He had surgery on the right knee back in May for an ACL tear and a complex medial meniscus tear. He still has pain in his left knee. He is scheduled for repeat surgery in the next 1-2 weeks. He had his BRC and everything went well. Physical Examination: He has decreased range of motion in both knees on flexion and extension. He has a positive Apley's, positive Smiley's, and positive patellar grind bilaterally with bilateral knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, lateral collateral ligament strain bilaterally, internal derangement of the bilateral knees. Plan: Continue his no work status for 30 days-pending surgery. Continue with physical therapy. Consider the work hardening program after he has had surgery. Follow up with his orthopedic consultations. Again, the MRI of his left knee with contrast was performed and that is not currently on the chart. Continue Tramadol, Naprosyn, and Elavil. He continues to get pain medication from his surgeon.

Physical Therapy from 10-9-08 through 10-14-08 (2 visits)

10-13-08 MD., the claimant continues to have pain, locking and catching on the right knee. Pain level is 6 out of 10. Taking Talwin-NX as needed. Right knee surgery was not authorized from as of 10-6-08. The evaluator does not know who denied that, either a nurse or a doctor, because they did not sign off on that. They did not call us for peer to peer to discuss it. It is the opinion of the reviewing physician that documentation supports the medical necessity of the diagnostic arthroscopy of the knee. The request, however, is for both medial and lateral meniscectomy and removal of loose body. The MRI generally does not describe loose body. Treatment options and recommendations by the reviewing physician were discussed with the claimant. Having just the diagnosis of left knee arthroscopy for and then followed by rehab and followed by therapeutic arthroscopy of the left knee invites two surgeries and that is improved. In my opinion, it should be combined together. The claimant will discuss with Dr. and let me know. In the meantime, he asked the evaluator to get authorization for left knee diagnostic arthroscopy to know his condition better. Hence, the evaluator will proceed with left knee arthroscopy for his left knee pain and swelling. Regarding the right knee, the evaluator will await letter from DDE physician before proceeding for ACL, etc. Impression: Status post surgery on 5-29-08 for right knee meniscus tear medial and lateral, right knee chondromalacia patella, potential for loose body formation, synovial hypertrophy, disruption of anterior cruciate ligament and right knee pain, left knee

clinically medial versus lateral meniscus tear, chondromalacia patella, potential for loose body formation and synovial hypertrophy. Plan: Continue to recommend physical therapy through Dr. . He states all therapy is being denied. Remain as active as possible at home using braces as necessary for intractable or increased pain. Discontinue bracing when pain is controlled to maintain strength and toning of bilateral knees and lower extremities. The claimant was prescribed Celebrex and Hyalgan. Due to positive pain and symptomatology and physical exam findings, the evaluator recommend left knee medial and lateral meniscectomy, chondroplasty, and removal of loose body or synovectomy at Medical Center. Pros and cons of surgery were discussed at greater length including but not limited to infection, wound complication, stiffness, post-traumatic arthritic changes, need for future surgery or surgeries, neurovascular or musculotendinous complications and prolonged rehab. No guarantees about the results or complications given.

10-22-08 MD., the claimant is here for preop for left knee diagnostic arthroscopy which has been scheduled for 11-4-08. Plan: Preop labs, chest x-ray and EKG were obtained in the office today. Consent form and H and P were reviewed with the claimant. Pros and cons of surgery were discussed at greater length including but not limited to infection, wound complication, stiffness, post-traumatic arthritic changes, need for future surgery or surgeries, neurovascular or musculotendinous complications and prolonged rehab. No guarantees about the results or complications given. All questions were answered to their satisfaction. Given prescription for physical therapy three times a week for four weeks through Dr.. Given prescription for Hydrocodone, Celebrex, Lunesta and VT unit through

11-3-08 DO., the claimant is scheduled for arthroscopic surgery tomorrow morning. He is quite excited about this He is hoping to get the popping sensation in his knee cleared up. Physical Examination: He has decreased range of motion in both knees on flexion and extension. He has a positive Apley's, positive Smiley's, and positive patellar grind bilaterally with bilateral knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, right ACL tear, status post surgical repair, bilateral lateral collateral ligament strain bilaterally, internal derangement of the bilateral knees. Plan: Continue his no work status for 30 days-pending surgery. Continue with physical therapy after surgery. Consider the work hardening program after he has been released by the surgeons. As noted, he has surgery tomorrow morning with Dr.. Continue medications he gets from Dr.. See him back in the office in a month.

11-4-08, MD., preoperative diagnosis: Left knee internal derangement and postoperative diagnosis: Left knee plica with the synovial hypertrophy all three compartment. Plan: Left knee diagnostic arthroscopy. Removal of the fibrocartilaginous loose body, synovectomy, and plica excision.

11-5-08 MD., the claimant is here for his first postop visit after left knee arthroscopy with synovial hypertrophy, plica and loose bodies which were removed on 11-4-08 at

Medical Center. Left knee pain with medication is 7 out of 10. He begins therapy aimed at the left knee tomorrow through Dr.

In regards to the right knee, the claimant states he has a court date set for 11-19. He was advised to keep that court date regarding future care of his right knee including possible full ACL reconstruction versus other treatment. Physical Examination: Left knee: Bulky postoperative dressing in place which was removed for physical examination. Two sutures in place at the medial and lateral joint line from previous arthroscopy. There is slight ecchymosis peri-incisional on the lateral aspect. There is a little bit of ecchymosis near the lateral femoral condyle lateral tibial plateau area. There is a little bit of joint effusion and inflammation. There is slight serous weeping from the medial portal site from the arthroscopy. Range of motion is 15 to 28-30 degrees. Impression: Status post surgery on 5-29-08 for right knee meniscus tear medial and lateral, right knee chondromalacia patella, potential for loose body formation, synovial hypertrophy, disruption of anterior cruciate ligament and right knee pain, left knee clinically medial versus lateral meniscus tear, chondromalacia patella, potential for loose body formation and synovial hypertrophy. Plan: Regarding the treatment of the right knee, the designated doctor was recently given an addendum of questions and did not change his opinion regarding the treatment of the right knee which includes the recommendation for future care stating that the ACL was compensable in the claimant's case and the evaluator do recommend that the claimant undergo full ACL reconstruction should instability catching, popping and locking remain. Of course, instability of the ACL can also cause damage to the other supporting structures of the knee, namely the meniscus or the osteochondral surfaces. The evaluator is requesting continued treatment versus complete reconstruction of the ACL to prevent any future ligamentous tear or injury or cartilaginous tear or injury to the osteochondral surfaces or the meniscal bodies. Regarding the left knee, we continue to recommend claimant undergo postoperative physical therapy starting 11-6-08 through Dr.. Continue postoperative medications. Other medication and work status per Dr.. Remove sutures. Shortly thereafter, the claimant will undergo court hearing for compensability and future treatment of the right knee. The evaluator does believe that this ruling will be in favor of the claimant since a state doctor supports continued treatment of the right knee.

Physical Therapy from 11-6-08 through 12-18-08 (14 visits)

11-9-08 X-ray of the left knee performed by MD., showed soft tissue edema and effusion. No acute bony abnormality.

12-1-08 DO., the claimant is one month post op on his left knee and he is scheduled to have his right knee ACL repair sometime in January. He continues to have some popping and discomfort in the knee. He has some difficulty getting in and out of the bathtub and going from a kneeling to standing position. Otherwise, he is progressing well. He is active in physical therapy. Physical Examination: He has decreased range of motion in both knees on flexion and extension. He has a positive Apley's, positive Smiley's, and positive patellar grind bilaterally with bilateral knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right

medial meniscus tear, right ACL tear, status post surgical repair, bilateral lateral collateral ligament strain bilaterally, internal derangement of the bilateral knees. Plan: Continue his no work status for another 30 days since he is post op. Continue with physical therapy. Consider the work hardening program after he has been released by the surgeons. Continue medications from Dr.. Follow-up in one month.

Psychotherapy from 12-16-08 through 2-27-09 (5 sessions)

1-12-09 DO., the claimant is scheduled for his ACL repair on his right knee. He is here for medication management only today. He continues to have some popping and discomfort in the knee as well as some crepitus. Otherwise, he is doing just fine. He is enrolled in college and is taking criminal justice courses.

Physical Examination: He has decreased range of motion in both knees on flexion and extension. He has a positive Apley's, positive Smiley's, and positive patellar grind bilaterally with bilateral knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, right ACL tear, status post surgical repair, bilateral lateral collateral ligament strain bilaterally, internal derangement of the bilateral knees. Plan: Continue his no work status for another 30 days since he is scheduled for surgery. Continue with physical therapy. Continue the work hardening program after he has been released by the surgeons. Continue medications from Dr.. The claimant was prescribed Elavil. See him back in the office in a month.

1-22-09 MD., the claimant is here for preop for right knee arthroscopic ACL repair, chondroplasty and loose body removal to be completed at Medical Center on 1-27-09. Plan: Preop labs, chest x-ray and EKG were obtained in the office today. Consent form and H and P were reviewed with the claimant. Pros and cons of surgery were discussed at greater length including but not limited to infection, wound complication, stiffness, post-traumatic arthritic changes, need for future surgery or surgeries, neurovascular or musculotendinous complications and prolonged rehab. No guarantees about the results or complications given. Given prescription for physical therapy three times a week for four weeks through Dr.. The claimant was prescribed Hydrocodone, Celebrex, Lunesta and VT unit through to help control postoperative pain and swelling. The claimant states he was recently approved for physical therapy regimen; however, claimant may see very little to no long lasting benefit in physical therapy that is done three to four days before his date of surgery.

1-27-09 MD., preoperative and postoperative diagnosis: Right knee anterior cruciate ligament tear, lateral femoral condyle, chondromalacia, traumatic, chondromalacia of patella, traumatic, loose body, synovial hypertrophy-internal derangement, status post right knee arthroscopy in the past xl. Procedure: Right knee arthroscopy redo with anterior cruciate ligament augmentation-repair. Chondroplasty of the medial femoral condyle and patella. Removal of loose body and synovectomy of all three compartments.

Physical Therapy from 2-2-09 through 4-20-09 (24 visits)

2-19-09 MD., the claimant returned for follow-up. Hinged knee brace was denied by insurance. This did not go to a physician peer review it appears that only utilizations reviewed this request. They even state the ODG criteria for the use of knee braces include "knee instability", the next indication "ligament insufficiency-deficiency" and the next indication "reconstructed ligament." The ninth indication is "painful unicompartamental osteoarthritis in addition to meniscal cartilage repair which was also noted as an indication for the brace. Per the operative report, the claimant currently suffers or has suffered in the past from all of these conditions. Therefore, he fits the criteria for more than 50% of the inclusion criteria of which only one criteria has to be met in order for a hinged knee brace to be approved and distributed to the claimant. The claimant is documenting continued instability especially immediately after surgery when he is weaker noting that he has fallen a couple of times. He states also that sometimes it is difficult for him to arise from a seated position with the first couple of steps being more unstable than the rest of the gait that follows thereafter. Impression: Status post right knee arthroscopy on 1-27-09 for ACL tear, posttraumatic chondromalacia, chondromalacia patella, loose body formation and synovial hypertrophy internal derangement NOS, status post surgery on 5-29-08 for right knee meniscus tear medial and lateral meniscus tear, status post partial meniscectomy, continued laxity of the ACL which was not addressed because of dispute by carrier, right knee chondromalacia patella, loose body formation, synovial hypertrophy addressed during scope in the past, left knee status post arthroscopy on 11-4-08 for synovectomy and loose body removal and meniscectomy, diagnostic arthroscopy for removal of body, synovectomy and plica excision. Treatment for chondromalacia patella, ACL mucoid degeneration. Plan: Continue to recommend right knee postoperative physical therapy modalities to be completed at Injury One. Regarding T-ROM hinged knee brace, we continue to support this be authorized by insurance and distributed to the claimant. Due to clear-cut rationale for indication as noted above, the evaluator will again send the prescription to our supplier. Other medication and work status per Dr.. Reassess in four to six weeks. Due to continued posttraumatic chondromalacia, he may be a candidate for steroid injection or Visco-supplementation with Synvisc-Orthovisc injections times three which should also help to increase his joint volume and help to decrease the instability. If bracing, injections and physical therapy fail to remedy his instability, the evaluator will recommend him as a candidate for a total right knee ACL reconstruction should laxity continues.

3-9-09 DO., the claimant continues to have pain in his knee. He has seen the orthopedic surgeons on 2-19-09. They have recommended right knee post operative physical therapy and a T-ROM hinge knee brace, which to this date has been disapproved. He may be looking at more surgery in the future. He continues to have popping, weakness, and instability of his right knee. He did work as a and he has concerns about going back into that line of work. The evaluator has suggested that he investigate the DARS program. Physical Examination: He has decreased range of motion in both knees on flexion and extension. He has a positive Apley's, positive Smiley's, and positive patellar grind bilaterally with bilateral knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat

pad syndrome, right medial meniscus tear, status post surgery, right ACL tear, status post surgical repair, bilateral lateral collateral ligament strain, bilaterally, internal derangement of the bilateral knees. Plan: Continue his no work status as he has not yet been released by the surgeons. Continue with physical therapy. He received no written prescriptions today. Continue to follow up with Dr. as directed.

3-19-09 MD., the claimant returned for follow-up visit. He recently has therapy sessions approved, two for the left and three for the right. Right knee pain and left knee pain is 4 out of 10. Status posts two right knee arthroscopies on 1-27-09 and 5-29-08. Left knee arthroscopy on 11-4-08. He continues to note instability, popping and catching of the right knee for which we had recommended a hinged knee brace. This was denied at first. Per the evaluator's understanding, it has now been approved and the evaluator is working with our representative to dispatch the brace to him as soon as possible. The evaluator will continue to recommend right knee bracing for approximately 60-90 days with reassessment. The claimant may be a candidate for ACL reconstruction. Regarding the left knee, he will continue conservative care with physical therapy and medication. Impression: Status post right knee arthroscopy on 1-27-09 for ACL tear, posttraumatic chondromalacia, chondromalacia patella, loose body formation and synovial hypertrophy internal derangement NOS, status post surgery on 5-29-08 for right knee meniscus tear medial and lateral meniscus tear, status post partial meniscectomy, continued laxity of the ACL which was not addressed because of dispute by carrier, right knee chondromalacia patella, loose body formation, synovial hypertrophy addressed during scope in the past, left knee status post arthroscopy on 11-4-08 for synovectomy and loose body removal and meniscectomy, diagnostic arthroscopy for removal of body, synovectomy and plica excision. Treatment for chondromalacia patella, ACL mucoid degeneration. Plan: Continue to recommend right knee hinged knee brace for 60-90 days with assessment thereafter for possible reconstruction of the anterior cruciate ligament should the claimant still have laxity, increased pain and effusion. Regarding left knee, continue to recommend active physical therapy modalities and therapy modalities approved for the right knee. Reassess in three weeks. Hopefully by this time he will have the brace and the evaluator will be able to assess whether this is beneficial at reducing his overall pain level.

Psychotherapy from 3-27-09 through 4-10-09 (2 sessions)

4-13-09 DO., the claimant continues to have pain, popping, and buckling in his right knee. He has a follow up in orthopedics next week. They have recommended surgery, if he continues to have laxity, pain, and effusion in his knee. He has multiple questions today regarding surgery and the knee brace he never received. He will address these subjects with his orthopedic surgeons next week. Physical Examination: He has decreased range of motion in both knees on flexion and extension. He has a positive Apley's, positive Smiley's, and positive patellar grind bilaterally with bilateral knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, status post surgery, right ACL tear, status post surgical repair, bilateral lateral collateral ligament strain, bilaterally, internal derangement of the bilateral knees. Plan: Continue his no work status as he has not yet

been released by the surgeons. Continue with physical therapy. The claimant was prescribed Naprosyn. Again, continue to follow up with Dr. next week and as directed. See him back in the office in a month.

4-23-09 MD., the claimant returned for follow-up visit. The evaluator will continue this bracing through approximately 6-19-09 and reassess from there. If the claimant has continued instability, he may be a candidate for ACL reconstruction. Right knee pain is 4 out of 10. Left knee has significantly decreased pain of 2 out of 10. No instability. He has a significant amount of popping, locking, and catching of the joint which could be from posttraumatic chondromalacia patella Grade I-II 2x2 cm. with a focal Grade IV lesion. The evaluator will initiate request for left knee Visco-supplementation. Impression: Status post right knee arthroscopy on 1-27-09 for ACL tear, posttraumatic chondromalacia, chondromalacia patella, loose body formation and synovial hypertrophy internal derangement NOS, status post surgery on 5-29-08 for right knee meniscus tear medial and lateral meniscus tear, status post partial meniscectomy, continued laxity of the ACL which was not addressed because of dispute by carrier, right knee chondromalacia patella, loose body formation, synovial hypertrophy addressed during scope in the past, left knee status post arthroscopy on 11-4-08 for synovectomy and loose body removal and meniscectomy, diagnostic arthroscopy for removal of body, synovectomy and plica excision. Treatment for chondromalacia patella, ACL mucoid degeneration. Plan: Regarding right knee, the evaluator will continue a more conservative care approach with bracing to increase stability. He has home exercise program which he completes and was advised to continue and progress as tolerated. Other medication and work status per Dr.. Regarding left knee, due to positive physical examination findings and pain, the evaluator will recommend left knee Visco-supplementation of hyalgan three pre-filled syringes to be administered to the left knee one every week for three consecutive weeks. The evaluator will also seek approval for times three. If Visco-supplementation is approved, the evaluator would prefer the claimant undergo physical therapy modalities through the treating doctor as ODG Guidelines indicate a modification of home exercise program or participation in active formal physical therapy program while undergoing Visco-supplementation.

5-11-09 DO., the claimant continues to have some discomfort, popping, and buckling in his right knee. He is scheduled for Synvisc injections x3 and physical therapy. He has his shots to start in the middle of June. Physical Examination: He has decreased range of motion in both knees on flexion and extension. He has a positive Apley's, positive Smiley's, and positive patellar grind bilaterally with bilateral knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, status post surgery, right ACL tear, status post surgical repair, bilateral lateral collateral ligament strain, bilaterally, internal derangement of the bilateral knees. Plan: Continue his no work status as he has not yet been released by the surgeons and is pending Synvisc injections into his knees. Continue with physical therapy. He received no written prescriptions today. Continue to follow up with Dr. as directed for his Synvisc injections starting in the middle of June. See him back in the office in a month.

5-21-09 MD., the claimant returned for follow-up visit. The claimant has been continuing right knee brace; however, he is not wearing the knee brace today. Left knee Visco-supplementation was authorized. The evaluator will begin today. Plan: Proceed with left knee hyalgan injection #1 using ultrasound guidance. Prescribed physical therapy three times a week for four weeks through Dr..

5-28-09 MD., procedure performed: Left knee hyalgan injection #2.

6-4-09 MD., procedure performed: Left knee hyalgan injection #3.

6-15-09 DO., the claimant has had Synvisc injections through Dr. office. He continues to have discomfort, popping, and buckling in his right knee. He is now experiencing back pain also. He has been seen by our physical therapist and he is encouraged to start some back strengthening exercises. He has a follow up appointment on 7-2-09. He is not happy with Dr. office and the evaluator will request a second opinion orthopedic evaluation. Physical Examination: He has decreased range of motion in both knees on flexion and extension. He has a positive Apley's, positive Smiley's, and positive patellar grind bilaterally with bilateral knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, status post surgery, right ACL tear, status post surgical repair, bilateral lateral collateral ligament strain, bilaterally, internal derangement of the bilateral knees. Plan: Continue his no work status as he has not yet been released by the surgeons and is still following up for his Synvisc injections. Request a second opinion orthopedic evaluation. Continue with physical therapy. He received no written prescriptions today.

6-17-09 DO., the claimant is requesting a second opinion for his knee pain. Dr. notes were reviewed from his visit on 6-4-09. Physical Examination: He has decreased range of motion in both knees on flexion and extension. He has a bilateral knee effusion. Further testing was not performed. Impression: Sprain-strain of the cruciate ligament, right knee, osteochondritis dessicans, right knee, chondromalacia patella, right knee, loose body in knee, right knee, plica syndrome, right knee, tear of medial cartilage or meniscus of knee, current, right knee, tear of lateral cartilage or meniscus of knee, current, right knee, chondromalacia patella, left knee, loose body in knee, left knee, plica syndrome, left knee, sprain-strain of cruciate ligament, left knee. Plan: No work for 30 days. Physical therapy evaluation and treatment. Second opinion orthopedic consultation. Continue medications. See him back in the office in a month.

6-25-09 DC., performed an Impairment Rating. He certified the claimant had reached MMI on 6-25-09 and awarded the claimant 6% whole person impairment.

7-2-09 MD., the claimant complains of pain in his knees. The evaluator does not feel the claimant is a candidate for ACL reconstruction surgery in the right knee and the left knee has shown significant process. Impression: Status postoperative right knee arthroscopy on 1-27-09 for ACL tear, posttraumatic chondromalacia, chondromalacia patella, loose body formation and synovial hypertrophy internal derangement NOS,

stats post surgery on 5-29-08 for right knee meniscus tear medial and lateral meniscus tear status post partial meniscectomy, continued laxity of the ACL which was not addressed because of dispute by carrier, right knee chondromalacia patella, loose body formation, synovial hypertrophy addressed during scope in the past, left knee status post arthroscopy on 11-4-08 for synovectomy and loose body removal and meniscectomy, diagnostic arthroscopy for removal of body, synovectomy and plica excision, treatment for chondromalacia patella, ACL mucoid degeneration. Plan: FCW is recommended. The claimant will continue home exercise program.

7-7-09 X-ray of the right knee performed MD., showed maintenance of joint space although there is some mild spurring starting on the lateral patella facet on this right knee. On the left knee, he has good joint space. Again, he has mild patella facet spurring. Otherwise, no significant osteophytes, no fractures noted intra-articularly.

7-7-09 MD., the claimant complains of pain in both knees that traveled up to his thighs. Impression: Status post arthroscopies x2 right knee with residual pain which is more significant than that of the left, status post left knee arthroscopy, deconditioned. Plan: The claimant should consider further conditioning. MR arthrogram of the right knee is recommended.

7-10-09 Functional Capacity Evaluation shows the claimant is functioning at a Medium PDL.

7-10-09 DO., the claimant complains of having knee pain. Impression: Knee pain, lateral collateral ligament laxity bilaterally. Plan: Work program is medically necessary. The claimant is cleared for Work Hardening. The claimant was prescribed Elavil.

Work Hardening from 7-13-09 through 8-12-09 (8 visits)

7-14-09 CT of the pelvis performed by MD., showed noncontrast CT scans of the abdomen and pelvis are within normal limits, allowing for limitations of noncontrasted study.

8-24-09 DO., the claimant complains of having knee pain. The claimant states he has discomfort, popping, and buckling in his right knee. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, status post surgical repair, right ACL tear, status post surgical repair, lateral collateral ligament strain, internal derangement bilateral knees. Plan: The claimant will continue Elavil. The evaluator requests a MR arthrogram of the claimant's right knee. The claimant was given Naprosyn.

10-16-09 Right knee arthrogram performed by showed, MD., showed arthrogram injection procedure was performed. The evaluator discussed the procedure with the claimant. Risk, benefits and alternatives were discussed. The claimant agreed to the procedure. The evaluator prepped and draped the right knee in a sterile fashion. Time-out was performed immediately prior to doing that. Subsequently, the skin and

subcutaneous tissues were anesthetized with Lidocaine. Subsequently, a 25-gauge needle was passed into the knee joint and 26 ml of solution was injected into the knee. The solution contained the standard 24 ml of saline, 0.2 ml of Gadolinium, and 2 ml of 1% Lidocaine. The type of Gadolinium solution is Omniscan. The claimant reports an iodine allergy so the evaluator did not use an iodinated contrast. The fluoroscopy demonstrated the needle within the knee joint. A small amount of gas did escape into the joint and what is seen at fluoroscopy did not confirmed position. Subsequently post-arthrogram MRI of the knee is performed.

10-16-09 MRI of the right knee with contrast performed by showed MD., showed evidence of previous medial meniscus surgery, and there is a re-tear of the posterior body and possibly the posterior horn of the medial meniscus. Lateral meniscus appears to be intact. The evaluator could not completely exclude minimal fraying at the edge of the lateral meniscus. Focal areas of grade 4 chondromalacia in the medial and lateral femoral condyle. There is a tiny focal area in the medial femoral condyle and a small 6-7 mm area in the lateral femoral condyle. Small amount of gas in the joint obtained during the procedure.

10-19-09 DO., the claimant is here for follow up of bilateral knee pain from an injury dating back to xx/xx/xx. He has had a recent MRI of his right knee on 10-16-09, which reveals evidence of a previous medial meniscus surgery. There is a re-tear of the posterior body and possibly the posterior horn of the medial meniscus. It also shows the lateral meniscus appears to be intact. Minimal fraying at the edge of the lateral meniscus could not be completely excluded. He has focal areas of Grade IV chondromalacia in the medial and lateral femoral condyle. There is a tiny focal area in the medial femoral condyle and a small 6-7 mm area in the lateral femoral condyle. There is a small amount of gas in the joint obtained during the procedure. Physical Examination: He has some decreased range of motion in both knees on flexion and extension. He has a positive Apley's, positive Smiley's, and positive patellar grind bilaterally with bilateral knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, status post surgery, right ACL tear, status post surgical repair, bilateral lateral collateral ligament strain, internal derangement of the bilateral knees. Plan: Allow him to continue to work fulltime. Continue in a modified work hardening program. He received no written prescriptions today. Follow up with Dr. based on the results of this recent MRI of 10-16-09.

11-3-09 MD., the claimant is seen in follow-up. He comes in today after having the MRI arthrogram performed on 10-16-09 at Medical Center. The evaluator has reviewed the study. The evaluator agrees that there is the presence of a medial meniscus tear; re-tear along the medial mid body and somewhat into the posterior horn. Obviously there are also some changes onto the cartilage surface. The lateral meniscus does appear to be grossly intact. Physical Examination: SLR does not reproduce any radicular pattern. He does have tenderness over the right knee. The tenderness is more in the medial joint line and he does have a positive McMurray's sign here. No neurosensory deficits reported in the lower extremity. Plan: The claimant would like to proceed with surgery

and the evaluator thinks that is a reasonable consideration given the MRI findings and his symptoms that correlate. The evaluator will get this set up at a mutually convenient time. He needs medical clearance preoperatively. The evaluator will keep him on light duty.

11-30-09 DO., the claimant is here for follow up of bilateral knee pain from an injury dating back to xx/xx/xx. His latest visit with Dr. was on 11-3-09 who has recommended surgery to repair a re-tear of his meniscus. He continues to have pain and discomfort. He continues to have stiffening of his knee; however he does continue to work part time. Physical Examination: He has some decreased range of motion in both knees on flexion and extension. He has a positive Apley's, positive Smiley's, and positive patellar grind bilaterally with bilateral knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, status post surgery, right ACL tear, status post surgical repair, bilateral lateral collateral ligament strain, internal derangement of the bilateral knees. Plan: Continue to work fulltime in a modified method. He received no written prescriptions today. Continue to follow up with Dr. who has recommended surgery. See him back in the office in a month.

12-19-09 DO., the claimant is still having knee pain. He is scheduled for right knee surgery later on this month. After that, the evaluator will do post op rehab, physical therapy, and possibly a work hardening program. Physical Examination: He has decreased range of motion in both knees on flexion and extension. He has a positive Apley's, positive Smiley's, and positive patellar grind bilaterally with bilateral knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, status post surgery, right ACL tear, status post surgical repair, bilateral lateral collateral ligament strain, internal derangement of the bilateral knees. Plan: No work x30 days. Physical therapy evaluation and treatment after surgery. Proceed with surgical intervention with Dr.. Consider work hardening program after physical therapy. Obtain permanent mobility restriction parking placard. See him back in the office on 1-9-10.

2-4-10 MD., preoperative and postoperative diagnosis: Internal derangement of the right knee with medial meniscus re-tear and possible lateral meniscus tear and chondrosis of the knee, the claimant is postop prior surgery. Procedure: Evaluation under anesthesia. Arthroscopy with partial medial meniscectomy of the midbody, posterior horn. Partial lateral meniscectomy, posterior horn and tearing free edge midbody. Microfracture of the medial femoral condyle measuring area of approximately 15 mm x 35 mm. Lateral femoral condyle microfracture, area approximately 25 mm diameter.

2-9-10 MD., performed a Designated Doctor Evaluation. He certified that the claimant had reached MMI on 2-9-10 and awarded the claimant 4% whole person impairment.

2-24-10 MD., the claimant returned for a follow up. He had his knee surgery done on 2-4-10. The evaluator had to do micro fracture of the medial and lateral femoral condyles as well as we did the medial and lateral partial meniscectomy. The good news is that he has not had much swelling but the bad news is due to his need to go to work since he

was not being compensated the evaluator were not able to actually get him the CPM. The evaluator have asked him at this point to get himself a stationary bike and then he can power it with the right leg and let the other leg ride free. The evaluator is going to also get him into therapy and have him do a biking program with him as well there. Plan: At this point the evaluator will get him back here in about six to seven weeks and see how he has done. He is already working which is at the school district, regular duty and the evaluator will keep him at that. Obviously the evaluator does not want him doing running and repetitive climbing, kneeling, or squatting.

Physical Therapy from 3-9-10 through 4-23-10 (9 visits)

4-2-10 R. PhD., the claimant presents for a psychological evaluation. Diagnosis: AXIS I: Major depressive disorder, single episode, severe, without psychotic features, generalized anxiety disorder, specific phobia. AXIS II: No Diagnosis. AXIS III: Knee injury. AXIS IV: Problems with primary support group, problems related to the social environment, educational problems (none), occupational problems, housing problems (none), economic problems, problems with access to health care services, problems related to interaction with the legal system-crime (none). Plan: The claimant will be referred to a Designated Doctor.

4-10-10 DO., the claimant complains of having severe knee pain. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, status post surgical repair, right ACL tear, status post surgical repair, lateral collateral ligament strain, internal derangement bilateral knees, persistent meniscus tear, right knee. Plan: The claimant will be on light duty work. Physical Therapy will continue. The claimant was given Mobic. Elavil was refilled.

4-24-10 DO., the claimant complains of having knee pain. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, status post surgical repair, right ACL tear, status post surgical repair, lateral collateral ligament strain, internal derangement bilateral knees, persistent meniscus tear, right knee, bilateral knee effusion, major depression and post traumatic stress disorder secondary and casually related to work injury. Plan: The claimant will remain off work for 30 days. The claimant will undergo a psychological evaluation as soon as possible. The claimant will continue medications as needed.

5-22-10 DO., the claimant complains of having knee pain. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, status post surgical repair, right ACL tear, status post surgical repair, lateral collateral ligament strain, internal derangement bilateral knees, persistent meniscus tear, right knee, bilateral knee effusion, major depression and post traumatic stress disorder secondary and casually related to work injury. Plan: The claimant will remain off work for 30 days. The claimant is not at MMI. The claimant will follow up with his BRC. The claimant will continue medications as needed.

6-4-10 MS., the claimant presents for a Psychological Evaluation. Diagnosis: Major depressive disorder, single episode, moderate, secondary to the work injury. Axis II: No diagnosis. Axis III: Injury to bilateral knees-See medical records. Axis IV: Primary support group and economic issues. Axis V: GAF-65 (current). Estimated pre-injury GAF = 85+. Plan: The claimant should receive immediate authorization for participation in a low level of individual psychotherapy for a minimum of 6 weeks. Unfortunately continues to deny his requested care. is disputing the relatedness of psychological symptoms. Because the claimant requires this care, the evaluator will continue to see him. Thus, the evaluator will request 6 sessions of individual psychotherapy to perform once a week. Results of the Beck Depression Inventory-TT (BDI-11) and the Beck Anxiety Inventory (BAT) reveal the following: The claimant scored a 25 on the BDI-II, indicative of moderate depression. He scored a 16 on the BAT, indicative of moderate anxiety.

6-23-10 DO., the claimant complains of having severe knee pain. The claimant states he had a popping and grinding sensation. The claimant is not a candidate for a total knee replacement because of his young age. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, status post surgical repair, right ACL tear, status post surgical repair, lateral collateral ligament strain, internal derangement bilateral knees, persistent meniscus tear, right knee, bilateral knee effusion, major depression and post traumatic stress disorder secondary and casually related to work injury. Plan: The claimant is not at MMI. The claimant will remain off work for 30 days. The claimant will continue psychological evaluation. The claimant will continue medication.

Psychotherapy from 6-24-10 through 9-14-10 (7 visits)

7-28-10 DO., the claimant complains of bilateral knee pain. He has had multiple surgeries on his knees. He is not a candidate for total knee replacement because of his young age at this time. However, he has bone to bone on x-ray and he will certainly be a candidate for knee replacement later in life. He has a follow up appointment with Dr. early next month. He is having difficulty sleeping, and he has arthritic type complaints. Physical Examination: His affect is good today. His range of motion in both knees is decreased somewhat due to the pain and discomfort. He is rather obese. He continues to demonstrate a positive Apley's, Smiley's, and Patellar Grind Test. He no longer has knee effusions, but he does continue to have an antalgic gate. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, status post surgical repair, right ACL tear, status post surgical repair, lateral collateral ligament strain, internal derangement bilateral knees, persistent meniscus tear, right knee, bilateral knee effusion, major depression and post traumatic stress disorder secondary and casually related to work injury. Plan: The claimant will be placed on light duty. The claimant was prescribed Naproxen and Ambien.

7-30-10 MD., the claimant currently complains of bilateral knee pain. He states he cannot run. He cannot sit for long periods of time. His knees constantly pop and he cannot climb stairs or ladders. The claimant describes his pain as a 5 to 6-10. It is even

worse when standing. It is also worse with twisting motions. The claimant states that he has been told by his surgeon he is not a candidate for a total knee replacement because of his age. He has also been told that he is basically disabled. Physical Examination: Examination of the right knee is compatible with an open procedure as well as two arthroscopic procedures. There is lateral laxity as well as some mild laxity on the anterior cruciate ligament and anterior drawer test. There is a negative grind test on the right. Crepitation is present on the right. There is mild fluid present in the right knee. The left knee shows crepitation. The left knee is stable. Drawer and grind tests are negative on the left. Impression: Bilateral knee pain, bilateral knee strain-sprain, right medial meniscus tear, status post surgical repair, right anterior cruciate ligament repair, collateral ligament strain on the right, internal derangement of the bilateral knees, persistent meniscus tear, right knee, bilateral knee effusions, right present and left cleared, posttraumatic depression, anxiety and insomnia, which is reactive and related to the chronicity of the injury plus the fact that he has been told he is disabled and will be unable to participate in his usual activities, the claimant has also been told nothing further can be done except knee replacement. Plan: Impairment rating needs to be re-evaluated. Then evaluator believe only assigning him 4% is inappropriate and should be re-checked. He should continue psychological consultation. The evaluator believes counseling sessions are the only thing that will keep him compensating while he awaits surgical intervention.

8-3-10 MD., the claimant comes today stating he has had several giving way episodes of his right knee. There is also crepitus and popping. The evaluator have had the discussion also that he was evaluated by someone from Social Security and states that he felt he had residual instability. The evaluator has done his examination under anesthesia and I did not feel that he had significant ACL laxity that would require operative intervention although there is that potential need. However, the evaluator thinks he needs a good brace regimen to see if that can discontinue the aspect of this sensation of giving way. The evaluator also wants him to work real diligently on the quadriceps and hamstring exercises which he is well aware of as well. Assessment-Plan: The claimant is at the point to get an ACL off the shelf brace. The claimant can return to regular duty.

8-13-10 MD., the claimant main complaints are on the right knee. He complains of swelling, locking, and weakness overall. He is still working intermittently and is set to go back on the 8-16. This claimant has many concerns regarding information given the understanding of what is an issue with his knee and the direction to proceed from here. Physical Examination: Right knee: Localized swelling of the lateral aspect. Anteromedial aspect was tender on palpation. Medial aspect was tender on palpation most. Lateral aspect was tender on palpation mild. Active motion 0-120. No erythema. No warmth. Patella demonstrated no crepitus. Anterior aspect was not tender on palpation. Patellofemoral region was not tender on palpation. No instability. No anterior drawer sign was present. No posterior drawer sign was present. No one plane medial (straight) instability. No one plane lateral (straight) instability. A Lachman test did not demonstrate one plane anterior instability. Anterolateral rotary instability with no active pivot shift. A McMurray test was negative. Clarke's sign was not observed. Left knee: Anteromedial

aspect was tender on palpation mild. Medial aspect was tender on palpation. No localized swelling. No erythema. No warmth. Patella demonstrated no crepitus. Anterior aspect was not tender on palpation. Lateral aspect was not tender on palpation. Patellofemoral region was not tender on palpation. Active motion was normal. Pain was not elicited at the extreme limits of the range of motion. No instability. No anterior drawer sign was present. A Lachman test did not demonstrate one plane anterior instability. Anterolateral rotary instability with no active pivot shift. A McMurray test was negative. Clarke's sign was not observed. Assessment: Osteoarthritis of the knee-right-tricompartamental, internal derangement of medial meniscus-right and left, internal derangement of lateral meniscus-right, patellar chondromalacia- left. Plan: The evaluator thinks any further arthroscopy is futile. His primary concern is grade IV chondromalacia and degenerative change, likely tricompartmental although he may be a candidate for a ConforMIS CT as he would be a candidate for a possible unicompartmental knee replacement. Otherwise, total knee replacement is in order for definitive treatment. With regard to the left knee, the evaluator thinks he has some mild meniscal pathology and likely has some mild underlying degenerative change also. The evaluator spoke to the claimant about these options. Any further ACL treatment or meniscal work or viscosupplementation or cortisone the evaluator think would be minimally effective and not recommended.

9-11-10 DO., the claimant is here complaining of knee pain. He has two conflicting stories from his orthopedic surgeon. Dr. i recommended a total knee replacement. Dr. recommended arthroscopic surgery. He is here to discuss this today. Physical Examination: His still has a flattened affect. He has decreased range of motion in the right knee on flexion and extension. He has a mild right knee effusion. Impression: Bilateral knee pain, bilateral knee sprain-strain, left quadriceps fat pad syndrome, right medial meniscus tear, status post surgical repair, right ACL tear, status post surgical repair, lateral collateral ligament strain, internal derangement bilateral knees, right greater than left, persistent meniscus tear, right knee, bilateral knee effusion, major depression and post traumatic stress disorder secondary and causally related to work injury. Plan: No work for 30 days. The claimant is not able to work awaiting surgical intervention. He is not at MMI. Contact his surgeon to proceed with total knee replacement. The evaluator will do post operative rehab and a return to work program. Continue his knee braces. See him back in the office in one month.

9-14-10 MS., the claimant continues to experience anxiety, stress, and symptoms of depression, 6 additional sessions are being requested in order to help him with stress management and improvement in his coping skills. Diagnosis: Pain Disorder associated with both psychological factors and a general medical condition, chronic, secondary to the work injury, Major Depressive Disorder, single episode, moderate, secondary to the work injury. Axis II: No diagnosis. Axis III: Knee injury as related to work injury (see medical record for specific diagnosis) Axis IV: Primary support group, economic problems, and occupational problems. Axis V: GAF = 60 (current). Estimated pre-injury GAF-85+. Plan: Cognitive behavioral therapy will assist the claimant in reframing his circumstances and becoming proactive in regards to his mental, emotional, and physical health, thus alleviating his symptoms of anxiety and depression. The claimant will learn

to self-regulate his emotions through stress management, progressive muscle relaxation, and guided imagery. The claimant will gain a greater sense of personal control and influence over his circumstances and functioning. The claimant will redirect focus from negative aspects of circumstances to engaging in health-promoting behaviors. The claimant will report cessation of negative thoughts as he will have learned other, more adaptive coping responses with treatment. The claimant will improve sleep hygiene from 5-6 fragmented hours of sleep to 7-8 hours of mostly uninterrupted sleep, partially met. The claimant will be further educated on the biopsychosocial model and how to successfully incorporate effective pain and tension management techniques via the assistance of instant visual and auditory feedback. With additional sessions, the claimant will work toward the following goals: Pain reduced from 5 to 3, tension reduced from 5 to 3, anxiety reduced from 5 to 3, sleep disturbance reduced from 8 to 5.

10-11-10 PhD., performed a Utilization Review. It was her opinion that the claimant was injured approximately xx year ago and has been treated with physical therapy, surgery, medications, injections, a work hardening program and 20 sessions of IPT. The claimant's Beck inventories scores remain relatively unchanged where as VAS scores indicate decreased muscle tension, nervousness and sadness/depression. The claimant has been provided extensive psychological treatment and education regarding pain management and coping skills to reduce psychological distress. The medical necessity of continuing with IPT at this time has not been established.

10-25-10 PhD., performed a Utilization Review. He noted the claimant has had 14 sessions of psychotherapy prior to reevaluation in June 2010 and 6 ore sessions since then. In spite of psychotherapy prior to reevaluation then and now, he is not on a therapeutic dose of anti depressants, only a small dose of Elavil at bedtime. He is working a new job but reportedly still struggling psychologically. There has been some improvement in some symptom areas based on his subjective ratings but compared to June Beck anxiety score, is much worse and Beck Depression score 2 points worse. At this point he has reached the ODG recommended maximum of 20 sessions with no significant improvement over the last set of visits. A therapeutic level of an anti depressant with anti anxiety effects needs to be added and its effects assessed before additional psychotherapy can be considered.

11-2-10 MD., performed a Designated Doctor Evaluation. He certified that the claimant had reached MMI on 2-6-10 and awarded the claimant 14% whole person impairment.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

The patient has an injury date of xx/xx/xx. He has had extensive treatment to date to include diagnostics, PT, injections, use of a knee brace, several surgeries with the last surgery being on 2/04/10, impairment ratings, consults, 20 sessions of IT from 9/08 through 9/14/10, several psychological evaluations, and medications. An IT reassessment dated 9/14/10 notes that the patient has increased frustration, is

employed and taking college courses, and his BDI increased from 22 to 24 and his BAI from 23 to 27. The patient has had multiple episodes of participation in IT to total 20 to date. His initial BDI on 2/29/08 was 11 and BAI was 6. His Beck scores have increased since and have steadily been in the 20s since with his last 6 IT sessions demonstrating increases in his depression and anxiety scores. As the patient has had multiple opportunities to participate in IT, has completed 20 IT sessions to date with the last IT sessions being seven months post his last surgery, his having shown little overall improvement, and the patient currently working and taking college courses, there is insufficient rationale to suggest that further IT would result in significant improvement. Based on the available information, the request does not appear to be reasonable and necessary, per evidence-based guidelines.

**ODG-TWC, last update 12-15-10** Mental Illness and Stress Chapter - Psychotherapy: Recommended. Cognitive behavioral therapy for depression is recommended based on meta-analysis that compare its use with pharmaceuticals. Cognitive behavior therapy fared as well as antidepressant medication with severely depressed outpatients in four major comparisons. Effects may be longer lasting (80% relapse rate with antidepressants versus 25% with psychotherapy). (Paykel, 2006) (Bockting, 2006) (DeRubeis, 1999) (Goldapple, 2004) It also fared well in a meta-analysis comparing 78 clinical trials from 1977-1996. (Gloaguen, 1998) In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. (Thase, 1997) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. (Corey-Lisle, 2004) A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. In longer therapies, the addition of psychotherapy helps to keep patients in treatment. (Pampaliona, 2004) The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy. The primary forms of psychotherapy that have been most studied through research are: Cognitive Behavioral Therapy and Interpersonal Therapy. (Warren, 2005)

**ODG Psychotherapy Guidelines:**

Initial trial of 6 visits over 6 weeks

With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions)

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

**AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**