

VLAD GENDELMAN, M.D., QME

JW

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CONFIDENTIAL

Patient's Name:	SANTILLAN, Maria Del Rosario
Social Security No:	XXX-XX-3894
Date of Birth:	03/26/1967
Date of Injury:	CT 01/01/2012 TO 04/08/2014; 02/22/2013
Employer:	Premier Staffing Management
Claims Administrator:	York Claims Services, Inc.
Claim No:	TWCS-1588
WCAB No:	ADJ9569723; ADJ9569722
Date of Examination:	08/20/2015
Date of Report:	08/20/2015

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR2) WITH REQUEST FOR AUTHORIZATION NEED FOR REFERRAL OR CONSULTATION AND NEED FOR SURGERY OR HOSPITALIZATION

Periodic Report (required 45 days after last report)
Need for referral or consultation
Need for surgery or hospitalization
Request for authorization

TO WHOM IT MAY CONCERN:

The above-referenced patient was seen for follow-up evaluation today. This patient indicated that she did not proficiently speak or understand the English language to assure accurate and meaningful communication with health care professionals regarding her medical condition and requested the assistance of an interpreter. Therefore, to secure precise reciprocal communication, I utilized an interpreter from "Premium Interpreting, Inc." to conduct this follow-up evaluation.

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SUBJECTIVE COMPLAINTS:

The patient complains of headaches as well as pain in the neck, mid/upper back, lower back, and left knee. On a scale of 0 to 10, with 10 representing the worst, her headaches are rated as 6/10 per the VAS scale, which have increased from 6/10 on the last visit; 8/10 in the neck, which has increased from 7/10 on the last visit; 2/10 in the mid/upper back, which has decreased from 6/10 on the last visit; and 8/10 in the lower back and left knee, which has remained the same since her last visit.

OBJECTIVE FINDINGS:

Cervical Spine: There is grade 2 to 3 tenderness to palpation over the paraspinal muscles, which has remained the same since her last visit. There is restricted range of motion. Cervical compression test is positive.

Thoracic Spine: There is grade 2 tenderness to palpation over the paraspinal muscles, which has decreased from grade 2 to 3 on the last visit. There is restricted range of motion.

Lumbar Spine: There is grade 3 tenderness to palpation over the paraspinal muscles, which has remained the same since her last visit. There is restricted range of motion. Straight leg raise test is positive bilaterally.

Left Knee: There is grade 3 tenderness to palpation, which has remained the same since her last visit. McMurray's test is positive.

Neurological: There are no changes on neurocirculatory examination.

COMMENTS:

- The patient is pending follow-up with Pain Management.
- MRI of the lumbar spine reveals disc herniations with stenosis.

DIAGNOSTIC IMPRESSION:

1. Headaches.
2. Cervical musculoligamentous strain/sprain.
3. Thoracic musculoligamentous strain/sprain.

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4. Lumbosacral musculoligamentous strain/sprain with radiculitis.
5. Lumbosacral disc herniations with stenosis, per MRI dated 04/15/15.
6. Left knee strain/sprain, degenerative joint disease, per MRI dated 12/15/14.

TREATMENT PLAN:

1. The patient is prescribed acupuncture therapy for evaluation and treatment of the cervical spine, thoracic spine, lumbar spine, and left knee, 2 times a week for 6 weeks.
2. She is prescribed FLURBI (NAP) Cream-LA (Flurbiprofen 20%/Lidocaine 5%/Amitriptyline 5%) 180 gm, to apply a thin layer to the affected areas 2 to 3 times a day and GABACYCLOTRAM (Gabapentin 10%/Cyclobenzaprine 6%/Tramadol 10%) 180 gm, to apply a thin layer to the affected areas 2 to 3 times a day.
3. She is referred for consultation with a neurologist.
4. I am recommending that the patient undergo left knee arthroscopy with possible partial medial meniscectomy, and this is to serve as an official request for authorization to perform said surgical procedure. Postoperative physical therapy is also requested for the left knee, 3 times per week for 4 weeks.

SURGERY CONSULTATION

Ms. Santillan has failed conservative management to include physical therapy, and injections. Subjectively, her pain level is an 8/10 and he complains of popping, clicking and locking. Objectively, she demonstrates limited flexion of the left knee, quadriceps atrophy, 4/5 muscle strength of the left quads/hamstrings, and a positive McMurray's test of the left knee. An MRI reveals a meniscal tear.

Based on the patient's subjective complaints, objective findings and diagnostic tests, she is in fact a candidate for an arthroscopic medial meniscectomy.

Please see the guidelines below, which support this request for surgery.

Additionally, she should also be approved for a preoperative screening prior to surgery, as well as 12 post operative physical therapy visits, as recommended by the post-surgical MTUS.

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The MTUS does not address the above referenced procedures, therefore additional guidelines should be considered during the determination of medical necessity.

The ACOEM states:

Surgical considerations

Referral for surgical consultation may be indicated for patients who have:

- Activity limitation for more than one month; and
- Failure of exercise programs to increase range of motion and strength of the musculature around the knee.

Earlier, emergency consultation is reserved for patients who may require drainage of acute effusions or hematomas. Referral for early repair of ligament or meniscus tears is still a matter for study because many patients can have satisfactory results with physical rehabilitation and avoid surgical risk.

ACOEM Guidelines, Chapter 13 (Knee Complaints: Surgical Considerations) (2004), pg 343-4

Meniscus Tears

Arthroscopic partial meniscectomy usually has a high success rate for cases in which there is clear evidence of a meniscus tear—symptoms other than simply pain (locking, popping, giving way, recurrent effusion); clear signs of a bucket-handle tear on examination (tenderness over the suspected tear but not over the entire joint line, and perhaps lack of full passive flexion); and consistent findings on MRI. However, patients suspected of having meniscal tears, but without progressive or severe activity limitation, can be encouraged to live with symptoms to retain the protective effect of the meniscus. If symptoms are lessening, conservative methods can maximize healing. In patients younger than 35, arthroscopic meniscal repair can preserve meniscal function, although the recovery time is longer compared to partial meniscectomy. Arthroscopy and meniscus surgery may not be equally beneficial for those patients who are exhibiting signs of degenerative changes.

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ACOEM Guidelines, Chapter 13 (Knee Complaints: Surgical Considerations) (2004), pg 344-5

Table 13-6. Summary of Recommendations for Evaluating and Managing Knee Complaints

Surgical considerations

Recommended

Arthroscopic meniscectomy or repair for severe mechanical symptoms and signs or serious activity limitations if MRI findings are consistent for meniscal tear (C,D)

ACL repair for symptomatic instability (i.e., serious activity limitation) if results of Lachman and pivot-shift tests and MRI are positive (C, D)

Optional: ACL reconstruction before rehabilitation has been attempted (C, D)

Not Recommended:

Surgical repair of isolated **MCL ruptures** (D)

Immediate surgical reconstruction of all ACL tears on basis of MRI findings without physical findings confirming diagnosis or worker life demands requiring high knee performance (D)

ACOEM Guidelines, Chapter 13 (Knee Complaints: Summary of Recommendations and Evidence) (2004), pg 347

The Official Disability Guidelines state:

Meniscectomy

Recommended as indicated below for symptomatic meniscal tears for younger patients and for traumatic tears. Not recommended for osteoarthritis (OA) in the absence of meniscal findings, or in older patients with degenerative tears until after a trial of PT/exercise. (Kirkley, 2008) Meniscectomy is a surgical procedure associated with a high risk of knee osteoarthritis (OA). One study concludes that the long-term outcome of meniscal injury and surgery appears to be determined largely

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by the type of meniscal tear, and that a partial meniscectomy may have better long-term results than a subtotal meniscectomy for a degenerative tear. (Englund, 2001) Another study concludes that partial meniscectomy may allow a slightly enhanced recovery rate as well as a potentially improved overall functional outcome including better knee stability in the long term compared with total meniscectomy. (Howell-Cochrane, 2002) The following characteristics were associated with a surgeon's judgment that a patient would likely benefit from knee surgery: a history of sports-related trauma, low functional status, limited knee flexion or extension, medial or lateral knee joint line tenderness, a click or pain noted with the McMurray test, and a positive Lachmann or anterior drawer test. (Solomon, 2004) Our conclusion is that operative treatment with complete repair of all torn structures produces the best overall knee function with better knee stability and patient satisfaction. In patients younger than 35, arthroscopic meniscal repair can preserve meniscal function, although the recovery time is longer compared to partial meniscectomy. Arthroscopy and meniscus surgery will not be as beneficial for older patients who are exhibiting signs of degenerative changes, possibly indicating osteoarthritis, and meniscectomy will not improve the OA. Meniscal repair is much more complicated than meniscal excision (meniscectomy). Some surgeons state in an operative report that they performed a meniscal repair when they may really mean a meniscectomy. A meniscus repair is a surgical procedure done to repair the damaged meniscus. This procedure can restore the normal anatomy of the knee, and has a better long-term prognosis when successful. However, the meniscus repair is a more significant surgery, the recovery is longer, and, because of limited blood supply to the meniscus, it is not always possible. A meniscectomy is a procedure to remove the torn portion of the meniscus. This procedure is far more commonly performed than a meniscus repair. Most meniscus tears cannot be treated by a repair. See also Meniscal allograft transplantation. (Harner, 2004) (Graf, 2004) (Wong, 2004) (Solomon-JAMA, 2001) (Chatain, 2003) (Chatain-Robinson, 2001) (Englund, 2004) (Englund, 2003) (Menetrey, 2002) (Pearse, 2003) (Roos, 2000) (Roos, 2001) Arthroscopic debridement of meniscus tears and knees with low-grade osteoarthritis may have some utility, but it should not be used as a routine treatment for all patients with knee osteoarthritis. (Siparsky, 2007) Asymptomatic meniscal tears are common in older adults, based on studying MRI scans of the right knee of 991 randomly selected, ambulatory subjects. Incidental meniscal findings on MRI of the knee are common in the general population and increase with increasing age. Identifying a tear in a person with knee

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pain does not mean that the tear is the cause of the pain. (Englund, 2008) Arthroscopic meniscal repair results in good clinical and anatomic outcomes. (Pujol, 2008) Whether or not meniscal surgery is performed, meniscal tears in the knee increase the risk of developing osteoarthritis in middle age and elderly patients, and individuals with meniscal tear were 5.7 times more likely to develop knee osteoarthritis. (Englund, 2009) AHRQ Comparative Effectiveness Research concluded that arthroscopic lavage for osteoarthritis, with or without debridement, does not improve pain and function for people with OA of the knee. (AHRQ, 2011) The repair of meniscal tears is significantly improved when performed in conjunction with ACL reconstruction. (Wasserstein, 2011) In patients with a nontraumatic degenerative medial meniscal tear and no knee osteoarthritis, arthroscopic partial meniscectomy is no better than sham surgery according to a high quality RCT. While arthroscopic partial meniscectomy is the most common orthopedic procedure performed in the U.S., rigorous evidence of its efficacy is lacking. While the results may argue against the current practice of performing arthroscopic partial meniscectomy in patients with a degenerative meniscal tear, the study did not compare meniscectomy with no treatment, because in the sham surgery group, they inserted an arthroscope and put fluid through the knee. (Sihvonen, 2013) Physical therapy vs. surgery: In older patients with degenerative tears and symptoms caused by osteoarthritis, PT/exercise may be an appropriate first option and it may be possible to reserve surgery for those who do not benefit from PT alone. A high quality RCT, the Meniscal Tear in Osteoarthritis Research (METEOR) trial, found similar outcomes from PT versus surgery for meniscal tears in older individuals. Researchers at seven major universities and orthopedic surgery centers around the U.S. assigned 351 people with arthritis and meniscus tears to get either surgery or physical therapy, nine sessions on average plus exercises to do at home. After six months, both groups had similar rates of functional improvement, and pain scores were also similar. While 30% of patients assigned to physical therapy wound up having surgery before the six months was up, often because they felt therapy wasn't helping them, they ended up the same as those who got surgery right away, as well as the rest of the physical therapy group who stuck with it and avoided having an operation. These results suggest that physical therapy maybe an appropriate first option for many patients with osteoarthritis and meniscal tears and that it may be possible to reserve surgery for those who do not benefit from physical therapy alone. (Katz, 2013) Another RCT comparing meniscectomy to strengthening exercises in patients

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presenting with degenerative medial meniscus tear and no clear evidence of osteoarthritis (Kellgren-Lawrence grade 0-1) found no significant between-group differences in function, pain, or patient satisfaction scores. (Yim, 2013) Arthroscopic surgery for knee osteoarthritis offers no added benefit to optimized physical and medical therapy, according to the results of a single-center, RCT reported in the *New England Journal of Medicine*. The study, combined with other evidence, indicates that osteoarthritis of the knee (in the absence of a history and physical examination suggesting meniscal or other findings) is not an indication for arthroscopic surgery and indeed has been associated with inferior outcomes after arthroscopic knee surgery. However, osteoarthritis is not a contraindication to arthroscopic surgery, and arthroscopic surgery remains appropriate in patients with arthritis in specific situations in which osteoarthritis is not believed to be the primary cause of pain. (Kirkley, 2008) In this RCT, arthroscopic partial medial meniscectomy followed by supervised exercise was not superior to supervised exercise alone in terms of reduced knee pain, improved knee function and improved quality of life, after non-traumatic degenerative medial meniscal tear in ninety patients, mean age 56 years. (Herrlin, 2007) See also Arthroscopic surgery for osteoarthritis.

ODG Indications for Surgery – Meniscectomy:

Criteria for meniscectomy or meniscus repair (Suggest 2 symptoms and 2 signs to avoid scopes with lower yield, e.g. pain without other symptoms, posterior joint line tenderness that could just signify arthritis, MRI with degenerative tear that is often false positive). Physiologically younger and more active patients with traumatic injuries and mechanical symptoms (locking, blocking, catching, etc.) should undergo arthroscopy without physical therapy.

1. Conservative Care: (Not required for locked/blocked knee.) Exercise/Physical therapy (supervised PT and/or home rehabilitation exercises, if compliance is adequate). AND (Medication. OR Activity modification [e.g. crutches and/or immobilizer].) PLUS

2. Subjective Clinical Findings (at least two): Joint pain. OR Swelling. OR Feeling of give way. OR locking, clicking, or popping. PLUS

3. Objective Clinical Findings (at least two): Positive McMurray's sign. OR Joint line tenderness. OR Effusion. OR Limited range of motion. OR Locking, clicking, or popping. OR Crepitus. PLUS

4. Imaging Clinical Findings: (Not required for locked/blocked knee) Meniscal tear on MRI (order MRI only after above criteria are met). (Washington, 2003)

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For average hospital LOS if criteria are met, see Hospital length of stay (LOS)

Diagnostic arthroscopy

Recommended as indicated below. Second look arthroscopy is only recommended in case of complications from OATS or ACI procedures, to assess how the repair is healing, or in individual cases that are ethically defensible for scientific reasons, only after a thorough and full informed consent procedure. (Vanlauwe, 2007) In patients with osteoarthritis, the value of MRI for a precise grading of the cartilage is limited, compared to diagnostic arthroplasty. When the assessment of the cartilage is crucial for a definitive decision regarding therapeutic options in patients with osteoarthritis, arthroscopy should not be generally replaced by MRI. The diagnostic values of MRI grading, using arthroscopy as reference standard, were calculated for each grade of cartilage damage. For grade 1, 2 and 3 lesions, sensitivities were relatively poor, whereas relatively better values were noted for grade 4 disorders. (von Engelhardt, 2010)

ODG Indications for Surgery – Diagnostic arthroscopy:

Criteria for diagnostic arthroscopy:

- 1. Conservative Care:** Medications. OR Physical therapy. PLUS
 - 2. Subjective Clinical Findings:** Pain and functional limitations continue despite conservative care. PLUS
 - 3. Imaging Clinical Findings:** Imaging is inconclusive.
- (Washington, 2003) (Lee, 2004)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

At this time, I am recommending left knee arthroscopy with possible partial medial meniscectomy. A formal surgical request is being submitted.

This patient has suffered an injury that has left dysfunction, disability, and chronic pain.

The trials of rest, time off work, therapy, medications and all other conservative methods have failed. This patient is faced with the choice of attempting to live with the pain or undergoing surgical intervention.

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I have discussed the treatment options, the alternatives, as well as risks and benefits. I have covered all usual and customary risks and benefits of surgery attendant upon hospitalization, immobilization, as well as anesthesia. We have discussed infection, nerve injury, pulmonary embolism and all other usual and customary complications. The patient accepts the risks and we are hereby requesting authorization for the performance of the surgery to assist in the improvement of quality of life, reduction of pain and resumption of some form of work.

This patient is fully aware of the risks. The patient is fully aware that there is no warranty or guarantee of complete or partial relief.

Recommendation for surgery is in keeping with the most accepted, standardized guidelines from orthopedic societies. This request also fits the algorithm for recommended treatment by ACOEM for this disorder. Additionally, it should be noted that in accordance with the Official Disability Guidelines, the patient has exhibited positive clinical findings/diagnostic studies, and has failed all other conservative attempts to relieve or cure this condition including physical therapy and medications.

Together with authorization for surgery, there is a need for preapproval for DME and post operative medication and physical therapy. Disability and patient outcomes depend upon approval in a timely manner so as to avoid worsening of the disorder, deconditioning and the development of a chronic pain syndrome. The procedure is required to cure or relieve the adverse effects of the industrial injury.

The patient is aware that this is the best available medical attempt at restoration of a near normal lifestyle, restoration of function, as well as an improvement in quality of life.

Topical medications were prescribed in order to minimize possible neurovascular complications; and to avoid complications associated with the use of narcotic medications, as well as upper GI bleeding from the use of NSAID's medications.

"Based on the patient's degree of progress with current treatment, I respectfully request timely authorization for the treatment plan outlined above. This request is per the Medical Treatment Utilization Schedule (**MTUS/ACOEM**) which was adopted by the Administrative

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Director pursuant to Labor Code Section 4610 and 5307.27 and set forth in California Code of Regulations, Title 8, Section 9792.20 et seq. The treatment plan is necessary in order to cure or relieve this patient's injury, and is consistent with **MTUS/ACOEM**. For all injuries not covered by the **MTUS/ACOEM**, treatment plans are in accordance with other evidence based medical treatment guidelines recognized by the national medical community and are scientifically based, such as the Official Disability Guidelines."

DISABILITY STATUS:

The patient remains temporarily totally disabled from 08/20/15 until 09/24/15. She needs current/future medical care.

"In order to adequately address the patient's return-to-work status, please provide a current job description, RU-90 or job analysis to our office for review. Upon receipt of same, the patient's current disability status and ability to return to modified duties will be addressed."

RETURN APPOINTMENT:

The patient is scheduled for a follow-up examination on 09/24/15.

I declare under penalty of perjury that this report is true and correct to the best of my knowledge, and that I have not violated Labor Code Section 139.3.



Vlad Gendelman, M.D., Cal.Lic #: A101034

Specialty: Orthopaedic Surgery

Executed at Los Angeles, CA

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