

Case Number:	CM13-0025674		
Date Assigned:	12/18/2013	Date of Injury:	01/16/2013
Decision Date:	03/04/2014	UR Denial Date:	07/30/2013
Priority:	Standard	Application Received:	09/18/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 53 year old male who reported an injury on 01/16/2013. The mechanism of injury was stated to be the patient was running to catch the elevator. The patient was noted to have give way feeling in his right knee. The patient was noted to have a pop sensation in the knee. The patient was noted to have recurrent knee effusions was intolerant of physical therapy, as the patient could not do it based on sharp stabbing pain that was experienced. The patient was noted to be unable to tolerate crouching, squatting, impact exercise, or physical therapy. The patient was noted to have mechanical symptoms. The patient was noted to have medial sided knee pain with Apley's compression and have a click and pain with a McMurray's test. The patient was noted to have diffuse tenderness over the posterior medial joint line. The patient's range of motion was noted to be 0 to approximately 125 degrees of flexion with further flexion intolerable. The request was made for postoperative physical therapy and for a partial medial meniscectomy and chondroplasty.

IMR ISSUES, DECISIONS AND RATIONALES

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

Eight Post Operative Physical Therapy visits 7/24/2013 and 9/7/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10 and 24.

Decision rationale: The California MTUS Postsurgical Treatment Guidelines indicate that the treatment for a meniscus tear of the knee is 12 visits over 12 weeks; however, the initial course of therapy means one-half the number of visits specified in the general course of therapy. As such, the recommended treatment would be 6 visits. The request for 8 postoperative physical therapy visits would be considered excessive. Given the above, the request for Eight (8) Post Operative Physical therapy visits between 7/24/2013 and 9/7/2013 is not medically necessary.

One Right Knee Arthroscopy with Partial Medial Meniscectomy and Chondroplasty:
Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Chondroplasty

Decision rationale: ACOEM Guidelines recommend a surgical consultation for patients who have failed an exercise program, have activity limitations for more than 1 month, and have clear evidence of a meniscus tear along with consistent findings on an MRI. Additionally, it was noted there should be clear signs of a bucket handle tear on examination revealing tenderness over the suspected tear, but not over the entire joint line. The clinical documentation submitted for review indicated the patient had activity limitation, failure of an exercise program, pain, effusion, giving way, tenderness over the posterior medial joint line, medial sided knee pain with Apley's compression test, and a positive click and pain with a McMurray's test. Additionally, the patient was noted to have mechanical symptoms and limitations. The patient was noted to have a tear on the MRI. This portion of the request would be supported. ACOEM Guidelines do not address a chondroplasty. The Official Disability Guidelines indicate that for a chondroplasty a patient should have conservative care including physical therapy and have subjective clinical findings of joint pain and objective findings of effusion or crepitus and a chondral defect on MRI. The clinical documentation submitted for review indicated the patient met the above criteria. Given the above, the request for One Right Knee Arthroscopy with Partial Medial Meniscectomy and Chondroplasty between 7/24/2013 and 9/7/2013 is medically necessary.