

<b>Case Number:</b>	CM13-0039597		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	03/14/2013
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	09/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/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:

This is a 79-year-old male with a 3/14/13 date of injury. He volunteers at a high school and was walking through the employee cafeteria when he slipped and fell on some water and his left knee and hip popped. A progress note dated 8/28/13 stated the patient complained of constant burning pain in the medial aspect of his knee and below the kneecap. He feels his gait is abnormal secondary to the knee pain, which has resulted in sciatic pain. He is noted to be working regular duty. Objective exam shows slight tenderness to the left knee. No effusion or atrophy. His ROM is 0-135 with crepitus. His SLR was performed well. A knee x-ray on 4/15/13 shows degenerative arthritis. A left knee MRI dated 5/21/13 showed a radial tear posterior horn medial meniscus and moderate chondromalacia of the patella and medial compartment. With mild degenerative changes of all three compartments. Diagnostic Impression: Knee arthralgia, Chondromalacia patella, knee medial meniscus tear. Treatment to date: Voltaren gel, knee sleeve. A UR decision dated 9/9/13 denied the request for arthroscopic surgery based on the fact that there was no evidence of conservative treatment including physical therapy, oral medication, or intraarticular corticosteroid injection. The MRI findings were consistent with the patient's age and there was no evidence of locking, popping, giving way, or recurrent effusion. The post-op physical therapy and polar compression unit were denied because the surgical intervention was not medically necessary. The pre-op physical therapy was modified to 6 sessions from 12 sessions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TWELVE (12) PRE-OPERATIVE PHYSICAL THERAPY SESSIONS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** The California MTUS Post-Surgical Treatment Guidelines supports up to 12 sessions of physical therapy over 12 weeks for meniscal and cartilage tears. However, since the initial surgical request was not found to be medically necessary, the associated peri-operative request cannot be substantiated. Therefore, the request for Post-Op Physical Therapy 3x4 was not medically necessary.

**LEFT KNEE ARTHROSCOPY INTRAARTICULAR SHAVING PARTIAL MENISECTOMY CHONDROPLASTY: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345.

**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 Chapter.

**Decision rationale:** The California MTUS states that arthroscopic partial meniscectomy usually has a high success rate for cases where there is clear evidence of a meniscus tear, symptoms other than simply pain, clear signs of a bucket handle tear on examination, and consistent findings on MRI. In addition, ODG criteria for meniscectomy include failure of conservative care. MTUS states that surgery may be indicated for patients who have: activity limitation for more than one month and failure of exercise programs to increase the range of motion and strength of the musculature around the knee. In addition, ODG does not recommend chondroplasty in the absence of a focal chondral defect on MRI. However, this patient has not yet had any conservative management, including physical therapy or a corticosteroid injection. He is noted to have degenerative disease on MRI and plain film radiographs. The ODG states that arthroscopic lavage and debridement in patients with osteoarthritis of the knee is no better than placebo surgery and arthroscopic surgery provides no additional benefit compared to optimized physical and medical therapy. In addition, there is no evidence of a chondral defect on MRI. Therefore, the request for Left Knee Arthroscopy, Intraarticular Shaving, partial meniscectomy, chondroplasty was not medically necessary.

**POLAR COMPRESSION FOR 21 DAY: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter.

**Decision rationale:** The California MTUS does not address this issue. The ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. However, ODG states that while there are studies on continuous-flow cryotherapy, there are no published high quality studies on the Game Ready device or any other combined system. There is no rationale identifying why a cryotherapy unit would be insufficient. There are no established risk factors for DVT. However, since the initial surgical request was not found to be medically necessary, the associated peri-operative request cannot be substantiated. In addition, this request is for a rental for 21 days, and guidelines only support up to 7 days. Therefore, the request for Polar Compression x 21 days was not medically necessary.

**TWELVE (12) POST OPERATIVE PHYSICAL THERAPY SESSIONS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Pain, Suffering, and the Restoration of Function Chapter 7 pg 114. Official Disability Guidelines (ODG) Knee Chapter: Physical Medicine Guidelines.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines support an initial course of physical therapy with objective functional deficits and functional goals. The ODG supports up to 9 sessions of physical therapy over 8 weeks for knee arthritis. The ODG recommends a "six-visit clinical trial" for physical therapy. Since this patient has a March of 2013 date of injury and has not yet had any physical therapy, physical therapy would be appropriate for this patient. However, this request is for 12 sessions and guidelines only support an initial trial of 6 sessions to establish efficacy and evaluate for functional improvement. The prior UR decision did modify this request to 6 sessions for an initial trial. Therefore, the request for Pre-op Physical Therapy 2x6 was not medically necessary.