MAXIMUS Federal Services

| Case Number: | CM13-0049402 | | |
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| Date Assigned: | 12/27/2013 | Date of Injury: | 04/29/2013 |
| Decision Date: | 02/28/2014 | UR Denial Date: | 10/31/2013 |
| Priority: | Standard | Application Received: | 11/07/2013 |

## 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 Illinois, Texas and West Virginia. 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 63-year-old male who reported an injury on 04/29/2013 when the patient stepped out of his vehicle and his left knee buckled causing a twisting motion of his right knee. He was treated conservatively with medications, injections, and physical therapy. The patient underwent an MRI of the right knee which revealed severe chondromalacia patella, moderate joint effusion with soft tissue edema and a partial tear of the popliteal tendon, and a degenerative tear of the posterior horn of the medial meniscus. The patient continued to complain of pain and swelling of his right knee that caused difficulty with entering and exiting his vehicle. Examination of the right knee revealed range of motion described as 0 degrees in extension to 135 degrees in flexion with popping/crepitus during range of motion testing bilaterally and pain, joint line tenderness of the bilateral knees, a positive McMurray's test on the right and a positive Apley's test on the right. The patient's diagnoses included right knee medial meniscus tear with underlying degenerative joint disease. The patient's treatment plan included surgical intervention and continuation of medications with postoperative treatments.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Right knee arthroscopy, medial/lateral meniscal tear repair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM,Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**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).

**Decision rationale:** The requested right knee arthroscopy, medial/lateral meniscal tear repair is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has a degenerative medial meniscus tear. The American College of Occupational and Environmental Medicine do recommend a meniscectomy for patients who have mechanical symptoms and an imaging study to support a lesion that would benefit from surgical intervention. It is also recommended that the patient has failed conservative treatment prior to surgical intervention. The clinical documentation submitted for review does indicate that the patient has failed to respond to nonsteroidal anti-inflammatory drugs, physical therapy, and injection therapy. It is also noted that the patient has notable crepitus and popping and pain with range of motion with joint line tenderness and a positive McMurray's test. However, Official Disability Guidelines state "arthroscopy and meniscus surgery will not be beneficial for older patients who are exhibiting signs of degenerative changes, possibly including osteoarthritis, and meniscectomy will not improve the osteoarthritis. 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 really mean a meniscectomy. A meniscus repair is a surgical procedure done to repair the damage to 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 is not always possible. A meniscectomy is a procedure to improve the torn portion of the meniscus. This procedure is far more commonly performed than a meniscal repair. Most meniscus tears cannot be treated by a repair." Due to the age of the patient and the degenerative changes to the meniscus, meniscal repair would not be supported over a meniscectomy. The clinical documentation submitted for review does not provide any exception factors to support treatment beyond guideline recommendations. The treating physician does not clearly indicate why a meniscal repair would be more beneficial over a meniscectomy for this patient who is older than 35 and has degenerative changes of the meniscus and the knee joint. Therefore, the requested meniscal repair surgical intervention is not indicated. Additionally, the clinical documentation submitted for review does not provide any evidence that the patient has a lateral meniscus injury that would require surgical intervention. Therefore, the right knee arthroscopy, medial/lateral meniscus tear repair is not medically necessary or appropriate

**Rehabilitation therapy (post operative physical therapy three (3) times a week for one (1) month):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM,Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

**Decision rationale:** The requested rehabilitation program (postoperative physical therapy) three (3) times a week for one (1) month is not medically necessary or appropriate. The California

Medical Treatment Postoperative Guidelines do recommend 12 visits of postoperative therapy for this type of surgery. However, the concurrent request for surgical intervention is not supported at this time. Therefore, postoperative treatment would not be indicated. As such, the requested rehabilitation therapy (postoperative physical therapy) three (3) times a week for one (1) month is not medically necessary or appropriate.

**Naprosyn:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM,Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 60, 67.

**Decision rationale:** The requested Naprosyn is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of medications for the management of a patient's chronic pain be supported by documentation of pain relief and functional benefit. The request as it is written does not include a frequency or duration. Therefore, the ability to reassess the use of this medication for efficacy is not established. Therefore, the need for this medication is not indicated.

**Prilosec:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM,Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68.

**Decision rationale:** The requested Prilosec is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of gastrointestinal protectants for patients who are at risk for developing gastrointestinal disturbances related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the patient's gastrointestinal system to determine the level of risk that the patient is at for developing gastrointestinal disturbances related to medication usage. Therefore, the need for a gastrointestinal protectant is not clearly established. As such, the requested Prilosec is not medically necessary or appropriate

**Medrox topical:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM,Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The requested Medrox topical is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend the use of topical analgesics as they are largely experimental and there is little scientific evidence to support the efficacy of this type of medication. The requested medication includes methyl salicylate, menthol, and capsaicin. California Medical Treatment Utilization Schedule does recommend the use of methyl salicylate and menthol for patients with osteoarthritic pain. The clinical documentation does include an MRI that supports degenerative changes of the right knee that may benefit from this type of medication. However, this compounded medication also includes capsaicin. California Medical Treatment Utilization Schedule does not recommend the use of capsaicin as a topical agent unless the patient has failed to respond to other first line treatments and oral analgesics. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to first line medications to include antidepressants or antiepileptics. Therefore, the need for Medrox as a topical agent is not medically necessary or appropriate.

**Post-operative Vicodin ES:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM,Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74.

**Decision rationale:** The requested postoperative Vicodin ES is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of opioids for breakthrough pain. However, the clinical documentation does not support the surgical intervention being requested. Therefore, postoperative management would not be indicated. As such, the requested postoperative Vicodin ES is not medically necessary or appropriate.

**DME: Interferential unit for a thirty (30) day trial:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM,Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118.

**Decision rationale:** The requested DME interferential unit x 30 day trial is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend a 30 day trial of an interferential unit when the patient has failed to respond to all other types of first line conservative care to include a TENS unit. The clinical documentation submitted for review does not provide any evidence that the patient's pain has failed to respond to a TENS unit. Additionally, California Medical Treatment Utilization Schedule does recommend the use of an interferential unit in the management of a patient's postsurgical pain. However, the concurrent request for surgical intervention is not supported by the submitted documentation. Therefore, the

need for an interferential unit for a 30 day trial is not established. As such, the requested DME: Interferential unit x thirty (30) day trial is not medically necessary or appropriate.