

Case Number:	CM14-0009525		
Date Assigned:	02/14/2014	Date of Injury:	08/01/2013
Decision Date:	07/08/2014	UR Denial Date:	01/07/2014
Priority:	Standard	Application Received:	01/24/2014

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 Surgeon 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 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:

The injured worker is a 56-year-old male who reported an injury on 08/01/2013. The mechanism of injury was not specifically stated. The current diagnoses include acute lateral meniscal tear, acute medial meniscus tear, contusion with intact skin surface of the left lateral knee, hydrarthrosis of the knee, infrapatellar bursitis, patellar tendinosis, sprained ACL of the left knee, and prepatellar bursitis. The injured worker was evaluated on 01/29/2014. The injured worker reported persistent knee pain with clicking and locking. Physical examination revealed diffuse swelling with 1+ effusion, tenderness in the lateral joint line, and negative tenderness in the medial joint line. Treatment recommendations at that time included authorization for surgical intervention. It is noted that the injured worker underwent an MRI of the left knee on 11/22/2013, which indicated a medial meniscus posterior horn horizontal tear and perimeniscal cyst, lateral meniscus horizontal tear of the posterior horn with degeneration, and mild to moderate patellofemoral, lateral and medial compartment degenerative osteoarthritis.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT KNEE ARTHROSCOPY, POSSIBLE ARTHROSCOPIC MEDIAL AND LATERAL MEINSECTOMY VERSES REPAIR, DEBRIEDMENT 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, Meniscectomy.

Decision rationale: California MTUS/ACOEM Practice Guidelines state referral for surgical consultation may be indicated for patients who have activity limitation for more than 1 month and a failure of exercise programs to increase range of motion and strength of the musculature around the knee. Arthroscopic partial meniscectomy has a high success rate for cases in which there is clear evidence of a meniscus tear with symptoms other than pain to include locking, popping, giving way, recurrent effusion, tenderness, and consistent findings on MRI. As per the documentation submitted, it is noted that the injured worker has previously participated in 6 sessions of physical therapy. However, there is no mention of an exhaustion of other conservative treatment to include activity modification or medication management. There is no objective evidence of positive McMurray's sign, limited range of motion, crepitus, locking, clicking, or popping as recommended by the Official Disability Guidelines. Based on the clinical information received, the injured worker does not currently meet criteria for the requested procedure. As such, the request is not medically necessary.

PRE-OPERATIVE MEDICAL CLEARANCE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

POSTOPERATIVE PHYSICAL THERAPY, THREE TIMES PER WEEK FOR SIX WEEKS (3X6) FOR THE LEFT KNEE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

CRUTCHES FOR THE LEFT KNEE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

POSTOPERATIVE ELECTRICAL STIMULATION UNIT FOR 90 DAYS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

COLD THERAPY UNIT FOR 90 DAYS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

CONTINUOUS PASSIVE MOTION (CPM) MACHINE FOR 14 DAYS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.