

Case Number:	CM14-0011041		
Date Assigned:	02/21/2014	Date of Injury:	01/18/2013
Decision Date:	06/25/2014	UR Denial Date:	01/15/2014
Priority:	Standard	Application Received:	01/27/2014

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 American Board of Orthopaedic 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:

The injured worker is a 59-year-old male who was injured on January 18, 2013. An MRI of the right knee is documented as having been obtained in November 15, 2013 which demonstrated a medial meniscus tear, medial compartment osteoarthritis, and a small joint effusion. Radiographs of the left knee obtained on November 15, 2013 insert moderate medial compartment joint space narrowing and early marginal osteophyte ptosis. The most recent clinical documentation available for this review is dated February 13, 2014. It indicates the orthopedic surgeon that the claim was referred to declined to see the patient. Difficulty walking or standing for greater than 5-10 minutes and popping, clicking of the knees is reported. The physical examination indicates a Body Mass Index (BMI) of 25, slight swelling of the left knee with range of motion from 0 to 120° and moderate to severe tenderness along the medial and lateral joint line with no ligamentous laxity. The right knee has moderately severe tenderness to palpation along the medial joint line and a positive McMurray's test. The utilization review in question was rendered on January 15, 2014. The reviewer partially certified the request for Synvisc injections left knee from five injections to three injections, non-certify the request for physical therapy to the right knee, not medically necessary a steroid injection for the right knee, not medically necessary a lateral wedge for the right knee, and not medically necessary Cosamin DS (glucosamine chondroitin). The reviewer indicates a peer-to-peer discussion was held with the treating clinician. The requested physical therapy for the right knee was deferred by an agreement with two clinicians as the right knee claim had only recently been accepted and an orthopedist had not yet evaluated the patient who had a meniscus tear. Similar rationale was given with regards to the right knee injection, lateral wedge, the requested Synvisc injections are modified from five to three in accordance with the guidelines and the Cosamin DS was not medically necessary noting that prior treatment with glucosamine chondroitin was utilized with no effect.

IMR ISSUES, DECISIONS AND RATIONALES

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

SYNVISC OR HYALGEN INJECTION TO THE LEFT KNEE QTY: 5.00: Upheld

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

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

Decision rationale: The MTUS and 2004 edition of American College of Occupational and Environmental Medicine (ACOEM) do not address the supplementation. The current edition of the ACOEM recommends the use of this injection for individuals with moderate/severe osteoarthritis. The guidelines for the Ghana note that up to three injections may be performed. This request exceeds the recommendation of the guidelines with no documentation of exceptional circumstances that would warrant deviation. As such, the request is considered not medically necessary.

PHYSICAL THERAPY TO THE RIGHT KNEE 2 TIMES A WEEK FOR 6 WEEKS QTY: 12.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Physical Medicine Page(.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The MTUS and ACOEM do not specifically address the number of physical therapy visits for the management of medial meniscus tears. However, the MTUS does address the use of physical therapy in the management of chronic pain and recommends up to a maximum of ten visits. When reviewing the ODG guidelines, up to nine physical therapy visits are recommended for non-operative management of a meniscus tear. This request significantly exceeds the guidelines in both the MTUS and ODG. As such, the request is considered not medically necessary.

STERIOD INJECTION RIGHT KNEE QTY: 1.00: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Knee corticosteroid injections

Decision rationale: The MTUS does not address this topic and the ACOEM offers no recommendation for or against the use of corticosteroid injections for management of knee pain. The patient fails to meet the criteria as outlined by the ODG. Specifically, the patient does not exhibit at least 5 of the 9 symptoms as outlined in the ODG recommendation. As such, the request is considered not medically necessary.

LATERAL WEDGE FOR THE RIGHT KNEE QTY: 1.00: Upheld

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

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

Decision rationale: This topic is not addressed by the MTUS or the 2004 version of the ACOEM. The current version of the electronic ACOEM recommends against the use of lateral edges for the treatment of chronic osteoarthritis. As such, the request is considered not medically necessary.

COSAMIN DS, #90 WITH 3 REFILLS: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: The MTUS supports the use of glucosamine chondroitin in the management of osteoarthritis. Based on clinical documentation provided, the request is considered medically necessary.