

<b>Case Number:</b>	CM14-0016101		
<b>Date Assigned:</b>	06/04/2014	<b>Date of Injury:</b>	03/13/2013
<b>Decision Date:</b>	08/07/2014	<b>UR Denial Date:</b>	01/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/07/2014

### 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 Psychiatry 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 patient is a 57-year-old male who has filed a claim for symptomatic right knee medial peripatellar synovial plica associated with an industrial injury date of March 13, 2013. Review of progress notes indicates right knee pain symptoms, and increased pain in the left shoulder. Findings of the right knee include tenderness over the medial retinaculum with a palpable peripatellar synovial plica, and mild-moderate effusion. There was no instability noted, and range of motion was full. Examination of the left shoulder showed tenderness and positive impingement sign. MRI of the left shoulder November 03, 2010 showed extensive rotator cuff tendinosis, with small partial or nonretracted full-thickness tear of the supraspinatus tendon and biceps tendinosis; and acromioclavicular joint osteoarthritis. MR arthrogram of the right knee dated December 10, 2013 showed chondromalacia patella. Ultrasound of the right knee dated August 21, 2013 showed medial meniscus mucoid and myxoid degeneration. Treatment to date has included right knee injection, chiropractic therapy, modified activity, rest, ice, opioids, and NSAIDs. Utilization review from January 28, 2014 denied the requests for right knee arthroscopic evaluation, arthroscopic medial plica resection, chondroplasty and debridement; pre-operative medical clearance; supervised post-operative rehabilitative therapy 3x4; home continuous passive motion (CPM) device for 14 days; surgistim unit for 90 days, then purchase; and coolcare cold therapy unit as there are no evidence of plica, effusion, or meniscal or ligament tear. The request for left shoulder diagnostic ultrasound was denied as there was no documentation of examination findings or failure of conservative care.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right knee arthroscopic evaluation:** Overturned

**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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations chapter pages 127 and 156 Official Disability Guidelines (ODG) Knee and Leg chapter, Chondroplasty.

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and ODG was used instead. According to ODG, diagnostic arthroscopy is indicated in patients with knee pain and functional limitations despite conservative care and inconclusive imaging results. In this case, the patient presents with chronic right knee pain symptoms, with examination findings showing a palpable plica and effusion. However, there are no findings of decreased range of motion and instability, and imaging studies did not show significant pathology except for chondromalacia patella. There is documentation that the patient has failed aggressive conservative therapy. At this time, an arthroscopic evaluation is a reasonable option for better visualization of the knee to guide further therapy. Therefore, the request for right knee arthroscopic evaluation was medically necessary.

**Right knee arthroscopic medial plica resection, chondroplasty and debridement:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**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, Chondroplasty.

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and ODG was used instead. According to ODG, indications for chondroplasty include conservative care; subjective findings of joint pain and swelling; objective findings of effusion, crepitus, or limited range of motion; and findings of chondral defect on MRI. In this case, the patient presented with full range of motion of the knee, and there was no significant pathology on the MRI. The examination findings and MRI results do not meet the criteria for the requested procedure. Therefore, the request for right knee arthroscopic plica resection, chondroplasty, and debridement was 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.

**Supervised post operative rehabilitative therapy; twelve (12) sessions (3X4): 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.

**Home continuous passive motion , cpm device for fourteen (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.

**Surgi Stim Unit for ninety (90) days, then purchase: 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.

**Coolcare Cold Therapy Unit: 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.

**Diagnostic ultrasound, left shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter, Ultrasound, diagnostic.

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and ODG was used instead. According to ODG, diagnostic ultrasound of the shoulders is recommended for detection of partial or full-thickness rotator cuff tears, and biceps pathologies. In this case, the patient presents with minimal findings of the left shoulder, showing tenderness and positive impingement sign. The indications for diagnostic shoulder ultrasound have not been met at this time. Therefore, the request for diagnostic ultrasound, left shoulder was not medically necessary.