

Case Number:	CM14-0114685		
Date Assigned:	08/04/2014	Date of Injury:	03/03/2014
Decision Date:	09/10/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	07/21/2014

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 Surgery 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 37-year-old male who reported an injury on 03/03/2014 after he used a hand truck to lift which slipped and reportedly caused an injury to the right knee. The injured worker was initially treated with physical therapy and medications. The injured worker underwent an MRI on 03/20/2014. It was noted that the injured worker had a complete proximal ACL disruption and a complex tear of the lateral meniscus and medial meniscus. It was also noted that the injured worker also had a grade I MCL and LCL sprain and multifocal osseous contusions in the medial and lateral compartments. It was noted that the injured worker had evidence of medial and lateral compartment arthrosis with joint effusion with synovitis. It was indicated there was no evidence of chondral defects. The injured worker was evaluated on 05/27/2014. It was noted that the injured worker had continued severe right knee pain. Objective findings included small joint effusion with range of motion limited to 110 degrees in flexion. The injured worker's diagnoses included right knee anterior cruciate ligament tear, right knee lateral meniscus tear, and right knee medial meniscus tear. Surgical intervention was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Manipulation, synovectomy, chondroplasty, abrasion, drilling: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute On-line Official Disability Guidelines-Knee & Leg (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Manipulation Under Anesthesia, Chondroplasty.

Decision rationale: The American College of Occupational and Environmental Medicine recommend surgical intervention for injured workers who have significantly limited functionality and physical findings consistent with pathology identified on an imaging study that has failed to respond to conservative treatments. The clinical documentation submitted for review does indicate that the injured worker has limited range of motion with effusion. However, manipulation, synovectomy, and chondroplasty, abrasion, and drilling is not addressed specifically in the American College of Occupational and Environmental Medicine recommendations. Official Disability Guidelines recommend manipulation of the knee after surgical intervention and postoperative physical therapy have failed to resolve significantly limited range of motion deficits. The clinical documentation does indicate that the injured worker has range of motion deficits. However, the clinical documentation does not support that the injured worker has been nonresponsive to physical therapy and would require manipulation under anesthesia. Furthermore, Official Disability Guidelines recommend chondroplasty for injured workers with significant pain and range of motion deficits that have failed to respond to conservative treatment and have a osteochondral defect identified on an imaging study. The clinical documentation submitted for review does not provide any evidence that the injured worker has an osteochondral defect on the submitted imaging study. Therefore, it is unclear why a chondroplasty would be necessary. Furthermore, the request as it is submitted, does not specifically identify an applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested manipulation, synovectomy, chondroplasty, abrasion, drilling is not medically necessary or appropriate.

Hot/Cold Therapy unit x 1 rental or purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute On-line Official Disability Guidelines-Knee & Leg (Acute & Chronic).

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, Continuous Flow Cryotherapy.

Decision rationale: The clinical documentation submitted for review does not support that the injured worker is a surgical candidate for the requested procedure. Official Disability Guidelines recommend continuous flow cryotherapy for up to 7 days in the postsurgical management of pain. The request does not specifically identify whether the unit will be for rental or purchase. Therefore, the appropriateness of the request itself cannot be determined. Furthermore, the request does not specifically identify an applicable body part. As such, the request hot/cold therapy unit times 1 rental or purchase is not medically necessary or appropriate.

