

Case Number:	CM14-0151918		
Date Assigned:	10/23/2014	Date of Injury:	07/04/2013
Decision Date:	11/20/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/17/2014

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 Orthopaedic 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 32 year old male with a date of injury on 7/4/2013. He was employed as a kitchen manager. The injury occurred when he struck his back on a cabinet door, and the cabinet door fell off and struck his left knee. The 9/19/13 left knee magnetic resonance imaging impression documented grade II signal intensity in the posterior horn and body of the medial meniscus, which did not reach an articulating surface. The findings documented chondromalacia changes of the patellofemoral joint with a full thickness cartilage defect. The progress reports from 2/14/14 to 7/21/14 reported persistent constant moderate left knee pain with popping, grinding, and occasional giving way. The review of system findings documented complaints of chest pain, heartburn with reflux, and abdominal pain. The records indicated the injured worker was overweight. The left knee exam findings documented swelling, peripatellar tenderness, range of motion of 0-115 degrees with crepitus, medial collateral ligament and lateral joint line tenderness, and positive McMurray's and anterior/posterior drawer signs. The injured worker's conservative treatment included anti-inflammatory medication, pain medication, physical therapy, hot/cold treatment, bracing, and a transcutaneous electric nerve stimulation unit without sustained improvement. The 7/7/14 left knee magnetic resonance impression documented joint effusion, horizontal oblique tear of the posterior horn of the medial meniscus, lateral patellar tilt with mild chondromalacia patella, and bipartite patella. The 8/12/14 treating physician report cited moderate to severe left knee pain and worsening compensatory right knee pain. His pain was not well controlled with medications. The physical exam documented tenderness over the medial joint line and medial collateral ligaments, with the left greater than the right, and over the peripatellar region. The McMurray's test was positive on the left. The range of motion was decreased. The worker was to follow-up with the orthopedist. The 9/9/14 utilization review

modified the request for left knee partial medial meniscectomy, chondroplasty, and debridement and approved an arthroscopic meniscectomy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Cold therapy unit: 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), Knee Chapter, Continuous Flow Cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), Continuous-flow cryotherapy

Decision rationale: The Official Disability Guidelines state that continuous-flow cryotherapy is an option for up to 7 days in the post-operative setting following knee surgery. The 9/9/14 utilization review decision recommended partial certification of a cold therapy unit for 7-day rental. There is no compelling reason in the records reviewed to support the medical necessity of a cold therapy unit beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.

Associated surgical service: CPM rental for 14 days: 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), Knee Chapter, CPM

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), Continuous passive motion (CPM)

Decision rationale: The Official Disability Guidelines recommended the use of continuous passive motion devices in the home for up to 17 days for workers who have undergone primary or revision total knee arthroplasty. There is no guideline support for the routine or prophylactic use of a continuous passive motion unit following knee arthroscopy. There is no compelling reason to support the medical necessity of continuous passive motion for this worker. Therefore, this request is not medically necessary.

Associated surgical service: Post op physical therapy for the left knee 3 times 4: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24 and 25.

Decision rationale: The Chronic Pain Medical Treatment Guidelines for meniscectomy and chondroplasty suggest a general course of 12 post-operative visits over 12 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 6 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. The 9/9/14 utilization review recommended partial certification of 6 initial post-operative physical therapy visits consistent with guidelines. There is no compelling reason submitted to support the medical necessity of care beyond guideline recommendations and the care already certified. Therefore, this request is not medically necessary.

Associated surgical service: Pre-op medical clearance: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Preoperative Testing

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38

Decision rationale: The evidence based medical practice advisory for preanesthesia evaluation guidelines indicate that a basic pre-operative assessment is required for all workers undergoing diagnostic or therapeutic procedures. The guideline criteria have been met based on review of systems, overweight status, long-term use of non-steroidal anti-inflammatory drugs, recumbent position, fluid exchange, and the risks of undergoing anesthesia. Therefore, this request for pre-operative medical clearance is medically necessary. The review of systems documented potential occult cardiac risk factors for this overweight worker.

Associated surgical service: Surgi-stim unit rental for 90 days: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: Under consideration is a request for post-operative Surgi-Stim rental. The Surgi-Stim unit provides a combination of interferential current, neuromuscular electrical stimulation, and galvanic current. The Chronic Pain Medical Treatment Guidelines for transcutaneous electrotherapy do not recommend the use of neuromuscular electrical stimulation in the treatment of pain. The guidelines suggest that interferential current is not recommended as

an isolated intervention. Galvanic stimulation is considered investigational for all indications. The guidelines support limited use of transcutaneous electrical nerve stimulation unit in the post-operative period. The guidelines have not been met. Arthroscopic knee surgery is planned. There is no indication that standard post-operative pain management would be insufficient. If one or more of the individual modalities provided by this multi-modality unit is not supported, then the unit as a whole is not supported. Therefore, this request for Surgi-stim unit rental for 90 days is not medically necessary.

Arthroscopic left knee partial medial meniscectomy, chondroplasty and debridement:
Overturned

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, 347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), Chondroplasty; Meniscectomy

Decision rationale: The Chronic Pain Medical Treatment Guidelines support arthroscopic partial meniscectomy for cases in which there is clear evidence of a meniscus tear including symptoms other than simply pain (locking, popping, giving way, and/or recurrent effusion), clear objective findings, and consistent findings on imaging. The Official Disability Guidelines criteria for chondroplasty (shaving or debridement of an articular surface) include evidence of conservative care (medication or physical therapy), plus joint pain and swelling, plus effusion or crepitus or limited range of motion, plus a chondral defect on magnetic resonance imaging. In this case, the guideline criteria have been met. This injured worker presents with mechanical symptoms and clinical exam findings consistent with imaging evidence of meniscal pathology and chondral defect. Evidence of recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request for arthroscopic left knee partial medial meniscectomy, chondroplasty, and debridement is medically necessary. There is imaging evidence in the provided records of a chondral defect to support the medical necessity of chondroplasty.