

Case Number:	CM14-0154864		
Date Assigned:	09/24/2014	Date of Injury:	05/13/1999
Decision Date:	10/27/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/22/2014

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 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:

This 55-year-old female sustained an industrial injury on 5/13/99. The mechanism of injury was not documented. Past medical history was positive for diabetes. Past surgical history was positive for left knee arthroscopy with partial medial meniscectomy and chondroplasty patella on 9/2/99, left knee diagnostic arthroscopy on 1/28/00, and left knee partial lateral meniscectomy and minimal chondroplasty patella on 11/6/00. The 10/21/13 left knee MRI demonstrated medial and lateral meniscus tears which appeared stable, joint effusion, chondromalacia patella, and prominent medial compartment degenerative changes with persistent edema in the far posterior medial femoral condyle. The 6/27/14 treating physician report indicated that the patient was taking Gabapentin and Nexium, and using a topical cream that helped to reduce pain. The left knee was reported as very painful and difficult to bend, with continued popping and giving out. The patient was not working or attending therapy. Objective findings documented crepitus medially and under the patella, medial and lateral tenderness, and positive McMurray's test medially and laterally. Range of motion was documented 0-115 degrees. The treatment plan recommended continued TENS unit use, continued custom knee brace, and physical therapy 2x8 for strengthening and to increase range of motion. A mini cyler had been requested. The patient was to have weight bearing x-rays prior to the next visit. Authorization for left knee arthroscopy with treatment as indicated and associated pre-operative and post-operative items was requested. The 8/22/14 utilization review denied the left knee arthroscopy and associated surgical requests based on an absence of documentation relative to failed conservative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 left knee arthroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-344. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg (Acute & Chronic)

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 and Leg, Diagnostic arthroscopy, Arthroscopic surgery for osteoarthritis; Meniscectomy, Chondroplasty

Decision rationale: The California MTUS state that surgical consideration may be indicated for patients who have activity limitation for more than one month and failure of exercise programs to increase range of motion and strength of the musculature around the knee. The Official Disability Guidelines criteria for diagnostic arthroscopy include medications or physical therapy, plus pain and functional limitations despite conservative care, plus inconclusive imaging findings. Arthroscopic surgery for osteoarthritis is not recommended. Guidelines state that arthroscopic surgery provides no additional benefit compared to optimized physical and medical therapy. Guideline criteria for chondroplasty and meniscectomy both require failure of conservative treatment, including exercise and physical therapy. Guideline criteria have not been met. There is no evidence that imaging is inconclusive to support the medical necessity of a diagnostic arthroscopy. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

1 preoperative chest x-ray and lab: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN), 2006 Jul. 33p.

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; ACR Appropriateness Criteria® routine admission and preoperative chest radiography. Reston (VA): American College of Radiology (ACR); 2011. 6 p.

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

7 day rental of a Cooling Unit: Upheld

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

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, Continuous flow cryotherapy

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

30 day rental of a TENS unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, post-operative pain (transcutaneous electrical nerve stimulation) Page(s): 116-117.

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

postoperative sessions of physical therapy for the left knee: Upheld

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

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

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

1 post surgery prescription of Hydrocodone/APAP/Ondansetron 5/300/2mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Hydrocodone/acetaminophen Page(s): 76-80, 91.

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