

Case Number:	CM14-0174276		
Date Assigned:	10/24/2014	Date of Injury:	09/10/2008
Decision Date:	12/03/2014	UR Denial Date:	10/13/2014
Priority:	Standard	Application Received:	10/20/2014

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 Spine Surgeon 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 42-year-old male who reported an injury on 09/10/2008. The mechanism of injury was not submitted for review. The injured worker has diagnoses of right knee recurrent medial meniscus tear, right knee tricompartmental degenerative changes, status post right knee arthroscopy with partial medial meniscectomy, and right knee chronic pain. Past medical treatment consists of surgery, physical therapy, medication therapy, and heat/ice packs. Medications consist of Norco, OxyContin, and Soma. An MRI that was reviewed revealed a recurrent tear to the posterior horn medial meniscus. There were postoperative changes noted of the meniscus with the majority of the meniscus having been debrided. There were early arthritic changes in the medial compartment and more advanced degenerative changes in the lateral compartment with a small area of what appeared to be full thickness articular surface loss. On 08/21/2014, the injured worker complained of right knee pain. The physical examination noted no swelling or deformity. There was a well healed incision. There was tenderness noted anteriorly both on the medial and lateral sides. Range of motion in extension was to 0 degrees and flexion to 130 degrees. Muscle strength was rated 5-/5. There was no instability noted. Distal vitals were intact. The medical treatment plan is for the injured worker to have a follow-up in 2 months and the use of a bone stimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

Follow-up in two (2) months with 4 view x-rays of the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG Pain, Office Visit.

Decision rationale: The request for follow-up in two (2) months with 4 view x-rays of the lumbar spine is not medically necessary. The Official Disability Guidelines recommend office visits for proper diagnosis and return to function of an injured worker. The need for a clinical office visit with a healthcare provider is individualized based upon a review of the injured worker's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. As injured worker's conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity of an office visit requires individual case review and assessment, being ever mindful that the best injured worker outcomes are achieved with the eventual injured worker independence from the healthcare system through self-care as soon as clinical feasible. The submitted documentation lacked any evidence regarding the injured worker's lumbar spine. It was noted in the documentation that the injured worker had pain of the right knee. However, there was no mention of lumbar pain. Additionally, there was no current clinical situation which would help determine when the injured worker would need to be seen again, and without that information, the necessity of follow-up visits cannot be determined. Given the above, the injured worker is not within the ODG recommended guideline criteria. As such, the request for follow-up in two (2) months with x-rays of the lumbar spine is not medically necessary.

Bone stimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation, guidelines outline criteria for use of invasive or non-invasive electrical bone growth stimulators.

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, Bone growth stimulators.

Decision rationale: The request for bone stimulator is not medically necessary. ODG recommend an electrical bone growth stimulator (EBS) uses electric current to promote bone healing. The current may generate a direct, direct pulsating or pulsating electromagnetic field (PEMF). Bone growth stimulators may be invasive, semi-invasive, or noninvasive. Direct current electrical bone growth stimulators may be appropriate for nonunion, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for 3 or more months despite appropriate fracture care. Criteria for the use of noninvasive electrical bone growth stimulators are as followed: Nonunion of long bone fracture (5% to 10% exhibit signs of delayed or impaired healing) must meet ALL of the following: - The 2 portions of the bone

involved in the nonunion are separated by less than 1 centimeter; AND - Location in the appendicular skeleton (the appendicular skeleton includes the bones of the shoulder girdle, upper extremities, pelvis, and lower extremities); AND - The bone is stable at both ends by means of a cast or fixation; AND - A minimum of 90 days has elapsed from the time of the original fracture and serial radiographs over 3 months show no progressive signs of healing (except in cases where the bone is infected, and the 90-day waiting period would not be required). The submitted documentation dated 08/21/2014 indicated that the injured worker had pain in the right knee. However, there was no indication that the injured worker had undergone any type of surgery. The ODG recommend electrical bone growth stimulators to promote bone healing. The guidelines also state that bone stimulators may be appropriate for nonunion, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for 3 or more months despite appropriate fracture care. There was no evidence submitted for review indicating the above. Given the lack of submitted evidence and the above guideline criteria, the injured worker is not within the guidelines. As such, the request for bone stimulator is not medically necessary.