

Case Number:	CM14-0053036		
Date Assigned:	07/07/2014	Date of Injury:	09/18/2008
Decision Date:	08/29/2014	UR Denial Date:	03/27/2014
Priority:	Standard	Application Received:	04/21/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine 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 60-year-old male with a 9/18/14 date of injury from repetitive loading. The diagnosis is bilateral knee patellofemoral syndrome. An MRI of the left knee from 8/25/12 revealed globular increased signal intensity in the posterior horn of the medial meniscus, most consistent with substance degeneration. A tear was not excluded. MR arthrogram from 9/21/12 was unremarkable, without evidence of a medial or lateral meniscal tear. A progress note dated 1/22/14 described increased left knee pain that caused difficulties with ambulation. Clinically, there was medial and lateral joint line tenderness; -15 of extension and 110 of flexion; and positive McMurray's. It was noted that an AME from 9/9/13 recommended left knee surgery under future medical care. A progress note dated 2/26/14 described ongoing left knee pain that is constant and moderate. Treatment to date has included acupuncture, 14 sessions of physical therapy, activity modification, steroid injection (12/11/13) with temporary pain relief, and medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left knee intra-articular injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Diagnostic Arthroscopy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339, 346. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter, Occupational Medicine Practice Guidelines, 2nd Edition (2004), pp. 339, 346.

Decision rationale: Medical necessity for the requested left knee intra-articular injection is not established. An associated request for meniscectomy obtained an adverse determination, as guideline criteria were not met. The diagnoses includes patellofemoral syndrome and the patient has had an injection in the past with reported temporary pain relief. The duration and extent of pain relief, as well as functional improvement was not discussed. It is not entirely clear if this request associated with the surgical treatment, which was not substantiated. There are no significant imaging findings of degenerative changes and the request for an intra-articular injection for the left knee is not substantiated.

Preoperative Comprehensive Metabolic Panel, Complete blood count, Prothrombin, and Partial thrombin time tests: Upheld

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

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

Left Knee Arthroscopy with Medial Meniscectomy 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, Indications for Surgery - Diagnostic Arthroscopy; Meniscectomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345.

Decision rationale: Medical necessity for the requested left knee arthroscopy with mastectomy is not established. This request obtained an adverse determination due to lack of corroborating imaging. Within the context of this appeal, this issue was not addressed. The California MTUS states that arthroscopic partial meniscectomy is indicated where there is clear evidence of a meniscus tear; symptoms other than simply pain, clear signs of a bucket handle tear on examination, and consistent findings on MRI. In addition, Official Disability Guidelines criteria for meniscectomy include failure of conservative care. Although the 8/25/12 MRI revealed some degenerative changes in the posterior horn of the medial meniscus, and the 9/21/12 MR arthrogram revealed no evidence of any lateral or medial meniscal tear. The imaging study was

entirely unremarkable. In addition, an AME from 9/9/13 reportedly recommended left knee surgery, however the report was not provided for review. Due to lack of corroborating imaging evidence of a meniscal tear, the request is not medically necessary.

Preoperative Medical Clearance with history and physical exam: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7 - Independent Medical Examinations and Consultations.

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

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