

<b>Case Number:</b>	CM14-0058527		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	04/30/2003
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	04/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2014

### 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:

The claimant is a 60-year-old gentleman who sustained an injury to the left knee on April 30, 2002. The report of an October 14, 2013, MRI of the left knee showed a ganglion cyst at the anterior cruciate ligament with chronic insertional tearing, Grade I chondral change to the patella and quadriceps tendinosis. An April 8, 2014, progress note documents continued complaints of pain, worse with weight-bearing, despite conservative care. Physical examination showed full range of motion, tenderness over the medial joint line and pain over the patellofemoral facet joint with palpation. There was no documentation of instability. The claimant was diagnosed with chronic quadriceps tendinosis with partial tearing of the anterior cruciate ligament. While the records reference failed conservative care, the specific conservative treatments were not specified. This request is for: left knee arthroscopy, chondroplasty and ACL debridement; an assistant surgeon; 12 sessions of postoperative physical therapy; the postoperative use of a cold therapy unit; the postoperative use of a compressive device; and the postoperative use of a knee brace.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Knee Arthroscopy, Chondroplasty, ACL Debridement:** 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 (Acute & Chronic) - Arthroscopy, Chondroplasty, Indications for Surgery - Chondroplasty, Diagnostic Arthroscopy, Anterior cruciate ligament (ACL) reconstruction.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-344. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: knee procedure - Chondroplasty Recommended as indicated below. Not recommended as a primary treatment for osteoarthritis, since arthroscopic surgery for knee osteoarthritis offers no added benefit to optimized physical therapy and medical treatment. (Kirkley, 2008) See also Meniscectomy. ODG Indications for Surgery -- Chondroplasty: Criteria for chondroplasty (shaving or debridement of an articular surface), requiring ALL of the following: 1. Conservative Care: Medication. OR Physical therapy. PLUS 2. Subjective Clinical Findings: Joint pain. AND Swelling. PLUS 3. Objective Clinical Findings: Effusion. OR Crepitus. OR Limited range of motion. PLUS 4. Imaging Clinical Findings: Chondral defect on MRI.

**Decision rationale:** Based on California MTUS ACOEM Guidelines and supported by Official Disability Guidelines, left knee arthroscopy, chondroplasty and ACL debridement would not be supported. To satisfy ACOEM Guidelines criteria in support of surgery, the claimant must have undergone an exercise program intended to increase strength, range of motion and function. While the reviewed records reference conservative care, they are non-specific on the type and duration of such care. Relative to the chondroplasty component of this surgery, the records document no structural lesion on imaging that has been shown to benefit in both the short- and long-term from operative intervention. Given the absence of specific conservative care and the claimant's clinical presentation related to the recommendation for chondroplasty, this request would not be medically necessary.

**Assistant Surgeon:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, CPT Procedure Code Index, Centers for Medicare and Medicaid services, Physician Fee Schedule Search, CPT Code 29870 - [http://www.cms.hhs.gov/pfslookup/02\\_PFSsearch.asp](http://www.cms.hhs.gov/pfslookup/02_PFSsearch.asp).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation - Other Medical Treatment Guideline or Medical Evidence: Milliman Care Guidelines 18th edition: assistant surgeon Assistant Surgeon Guidelines (Codes 29240 to 29894) CPT® Y/N Description 29881 N Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed.

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

**Twelve (12) Sessions of Post-Operative Physical Therapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

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

**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: Knee & Leg (Acute & Chronic): Continuous-flow cryotherapy, cold therapy/unit polar care.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-339.

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

**Compression 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: Knee & Leg (Acute & Chronic): Compression Garments, Venous thrombosis.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: forearm/wrist/hand procedure - Vasopneumatic devices Recommended as an option to reduce edema after acute injury. Vasopneumatic devices apply pressure by special equipment to reduce swelling. They may be considered necessary to reduce edema after acute injury. Education for use of lymphedema pump in the home usually requires 1 or 2 sessions. Further treatment of lymphedema by the provider after the educational visits is generally not considered medically necessary. The treatment goal of vasopneumatic devices, such as intermittent compression therapy, is to reduce venous hypertension and edema by assisting venous blood flow back toward the heart. (McCulloch, 1995) (Moseley, 2007) See also Lymphedema pumps.

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

**Knee Orthosis Brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee and Leg (Acute & Chronic): Anterior cruciate ligament (ACL) reconstruction, Knee Brace, Immobilization.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints  
Page(s): 340.

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