

Case Number:	CM14-0067505		
Date Assigned:	07/11/2014	Date of Injury:	04/22/2011
Decision Date:	10/01/2014	UR Denial Date:	04/08/2014
Priority:	Standard	Application Received:	05/12/2014

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 & Rehabilitation 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 51-year-old male who has submitted a claim for status post right knee surgery/menisectomy, rule out neuroma, saphenous nerve (infrapatellar branch), chondromalacia of patella, pain in lower leg joint, cervical degenerative intervertebral disc, and tear of right knee medial cartilage/meniscus associated with an industrial injury date of April 22, 2011. Medical records from 2013-2014 were reviewed. The patient complained of pain and mechanical symptoms with burning sensation on the inner aspect of his right knee. Physical examination showed well-healed arthroscopic portals. Range of motion of the right knee was decreased. There was tenderness to palpation in the medial aspect of the right knee (infrapatellar region). Mild allodynia was noted on touch and pressure. Tinel's sign was positive over the infrapatellar branch of the saphenous nerve. MRI of the right knee, dated August 28, 2013, revealed prior medial menisectomy with a macerated tear of the posterior horn of the medial meniscus, medial compartment osteoarthritis with mild-to-moderate chondromalacia without gross erosion, and mild patellofemoral chondromalacia with mild chondromalacia of the lateral compartment. Official report of the imaging study was not available. Treatment to date has included medications, physical therapy, home exercise program, activity modification, right knee diagnostic and operative arthroscopy, lumbar epidural steroid injection, right knee viscosupplementation, and trigger point injections. Utilization review, dated April 8, 2014, denied the request for U/S guided injection/block of infrapatellar branch of saphenous nerve with cryoablation because there was no indication that the diagnosis has been confirmed by injection with a local anesthetic prior to considering cryoablation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound (U/S) guided injection/block infrapatellar branch of saphenous nerve with cryoablation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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 Chapter, Nerve excision (following TKA)

Decision rationale: CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. According to ODG, excision of neuromas of the infrapatellar branch of the saphenous nerve in total knee arthroplasty (TKA) is recommended, but not solely for post-TKA incisional pain. Consideration for this procedure requires pain of at least a 1-year duration, failure of conservative management, pain localization at a Tinel's point, and at least a 5-point reduction of pain on a visual analog scale after nerve blockade with 1% lidocaine. Peripheral sensory nerve procedures to treat knee pain after total knee arthroplasty may include surgical resection or radiofrequency ablation of sensory nerves about the knee. Injury of the infrapatellar branch of the saphenous nerve (ISN) may be caused by a surgical laceration or trauma about the knee and can result in formation of a painful neuroma. A neuroma of the ISN may be resected, and the pain as well as the stiffness of the knee resolves. In this case, the request was presumably for the consideration of neuroma on the infrapatellar branch of the saphenous nerve in the right knee. However, there was no clear rationale provided for the requested service. The patient had right knee pain since his industrial injury of April 2011. Tinel's sign was positive over the infrapatellar branch of the saphenous nerve. Patient had injections on the right knee with good relief. However, objective evidence of pain reduction was not documented. Guidelines state that procedures to treat knee pain after total knee arthroplasty may include surgical resection or radiofrequency ablation. However, there was no mention regarding the use of cryoablation. Moreover, the patient did not undergo total knee replacement yet. The medical necessity has not been established. Furthermore, the present request failed to specify the laterality. Therefore, the request for Ultrasound (U/S) guided injection/block infrapatellar branch of saphenous nerve with cryoablation is not medically necessary.