

Case Number:	CM14-0068342		
Date Assigned:	07/14/2014	Date of Injury:	06/11/2001
Decision Date:	08/11/2014	UR Denial Date:	04/03/2014
Priority:	Standard	Application Received:	05/13/2014

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 48-year-old male sustained an industrial injury on 6/11/01. The patient had a traumatic above knee amputation on the right and a compensable left knee injury when he stumbled and fell at work. The 2/20/14 treating physician note indicated the patient had increasing left knee pain, especially with single stance gait on the left. He had pain, catching, locking, and gives way with pivot. Symptoms caused significant impact on activities of daily living. Physical exam documented range of motion 0-130 degrees, fair effusion, and strongly positive McMurray and Apley tests in the medial joint line. The treatment plan recommended proceeding with diagnostic arthroscopy of the left knee with meniscectomy, chondroplasty, and other necessary procedures. The 3/11/14 left knee MRI impression documented trace joint effusion and questionable mild patella chondromalacia. There was no internal derangement identified. Medial and lateral menisci were reported normal without evidence of tear. The 3/13/14 treating physician report cited significant medial left knee pain along the medial joint line, pain to hyper flexion of the knee, and history of giving way. The MRI was reviewed. The treating physician noted that the meniscal tear found on the 2011 MRI was not present. He opined there was internal derangement and requested diagnostic arthroscopy and debridement. The 4/3/14 utilization review was not granted the left knee surgery request and associated items as guideline criteria had not been met relative to clinical and imaging findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left knee arthroscopy, chondroplasty, abrasion of patella: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Chondroplasty, Diagnostic arthroscopy.

Decision rationale: The California MTUS state that surgical referral 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. Guidelines state that arthroscopic patellar shaving is frequently performed for patellofemoral syndrome, but long-term improvement has not been provided and its efficacy is questionable. The Official Disability Guidelines criteria for chondroplasty include evidence of conservative care (medication or physical therapy), plus joint pain and swelling, plus effusion or crepitus or limited range of motion, plus a chondral defect on MRI. Diagnostic arthroscopy is recommended when clinical indications are met. Indications include medications or physical therapy, plus pain and functional limitations despite conservative treatment, and imaging is inconclusive. Guideline criteria have not been met. There is significant functional limitation due to pain and single stance required by amputation status. However, there is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. There is no imaging evidence of a chondral defect or internal derangement. There is questionable mild chondromalacia patella noted on the MRI. Given the absence of documented conservative treatment failure or clear imaging findings, the request for left knee arthroscopy, chondroplasty, and abrasion of patella is not medically necessary.

Twelve postoperative physical therapy sessions: 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.

One pair of crutches: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (acute & chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338-340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Walking aids (canes, crutches, braces, orthoses, & walkers).

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

One 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 (ODG) Knee & leg (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) Knee and Leg, Continuous flow cryotherapy.

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