

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0084998 | | |
| Date Assigned: | 07/23/2014 | Date of Injury: | 05/28/2011 |
| Decision Date: | 08/27/2014 | UR Denial Date: | 05/30/2014 |
| Priority: | Standard | Application Received: | 06/06/2014 |

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 Texas and Colorado. 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 51-year-old female who reported an injury on 05/28/2011 due to an unknown mechanism. The injured worker reportedly sustained an injury to her right knee and low back. The injured worker's treatment history included aquatic therapy and injection therapy. The injured worker was evaluated on 04/16/2014. It was noted that the injured worker had persistent right knee and low back pain complaints. Right knee complaints included mechanical symptoms and trouble getting up and down stairs. Objective findings included restricted range of motion described as 180 degrees in right-sided extension and 140 degrees in right-sided flexion with a positive patellofemoral clicking and lateral tracking. The injured worker's diagnoses included right knee patellofemoral chondromalacia malalignment, right knee internal joint derangement, knee chondromalacia. The injured worker's treatment plan included surgical evaluation and treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right knee arthroscopy, debridement, possible meniscectomy & lateral release as needed:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation ODG(The Official Disability Guidelines) Knee & Leg (Acute & Chronic) Meniscectomy.

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

Decision rationale: The requested Right knee arthroscopy, debridement, possible meniscectomy & lateral release is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine requires that surgical intervention for knee injuries be supported by physical examination. The findings should be consistent with pathology identified on an imaging study that has failed to respond to conservative treatment. The clinical documentation submitted for review indicates that the injured worker has failed to respond to physical therapy, aquatic therapy, and injection therapy. However, the clinical documentation submitted for review does not provide significant limitations to support the need for surgical intervention. Additionally, the clinical documentation did not provide any evidence of an MRI that identified pathology consistent with the surgical request. Therefore, the need for surgery is not supported. As such, the requested Right knee arthroscopy, debridement, possible meniscectomy & lateral release is not medically necessary or appropriate.

Pre-operative clearance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported and the request is considered not medically necessary.

Cold therapy unit QTY: 1: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported and the request is considered not medically necessary.

Post-operative brace: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported and the request is considered not medically necessary.

Post-op physical therapy 2 times a week for 6 weeks QTY: 12: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported and the request is considered not medically necessary.