

Case Number:	CM14-0088359		
Date Assigned:	07/23/2014	Date of Injury:	09/11/2013
Decision Date:	09/22/2014	UR Denial Date:	05/23/2014
Priority:	Standard	Application Received:	06/12/2014

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 Internal 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 who was injured on 09/11/2013. The mechanism of injury is unknown. The patient underwent a right knee arthroscopy with removal of loose bodies and a partial meniscectomy and chondroplasty on 04/16/2014. Prior treatment history has included Diovan. He also underwent right knee arthroscopy with arthroscopic irrigation and debridement, complete synovectomy; and right knee arthroscopy with arthroscopic partial lateral meniscectomy, infected psoterior horn of lateral meniscus on 05/11/2014. Diagnostic studies reviewed include MRI of the right knee dated 10/15/2013 demonstrated a small tera of the posterior horn of the medial meniscus; extensive tear of the lateral meniscus with lateral extrusion of the meniscal body and possible bucket-handle component; moderate degenerative changes in the lateral compartment with joint space narrowing, chondromalacia; osteophyte formation and subcondral edema; osteoarthritic changes of the patellofemoral and medial compartments; and joint effusion. An office visit dated 05/11/2014 indicates the patient was doing well postoperatively. He rated his pain as 4/10. He returned to the office with a swollen knee and tense effusion. He reported worsening pain. He had cultures performed of the knee and results revealed a Staph infection. It is noted that is it not certain as to whether this is a contaminant versus a true septic arthritis. Objective findings on exam revealed a large effusin of the right knee with some mild warmth. The leg below the knee is swollen and there is no spreading cellulitis. Diagnoses are rule out right knee septic arthritis, coagulase negative staphylococcus; and history of previous righ tknee arthroscopy on 04/16/2014. The plan is debridement of the right knee. He was scheduled for surgery on 05/11/2014 and preoperative workup was requested. Prior utilization review dated 05/12/2014 states the request for an Inpatient stay, Admitted on 5/10/14, Qty: 1.00.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inpatient stay, Admitted on 5/10/14, Qty: 1.00: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<http://www.ncbi.nlm.nih.gov/pubmed/23906274>;
<http://www.ncbi.nlm.nih.gov/pubmed/15366667>.

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: <http://www.ncbi.nlm.nih.gov/pubmed/23906274>.

Decision rationale: The guidelines recommend aggressive management including intravenous antibiotics and emergency surgery when septic arthritis is a possible diagnosis. The clinical documents establish that the patient had increased swelling and pain with decreased range of motion 2 weeks following knee surgery. The signs/symptoms were consistent with septic arthritis. The documents also identify he had a positive culture from the joint fluid. The patient did require admission to the hospital with IV antibiotics and urgent surgery. Based on the guidelines and criteria as well as the clinical documentation stated above, the hospital stay was medically necessary.