

<b>Case Number:</b>	CM14-0093028		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	01/28/2008
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	06/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/19/2014

### 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 55-year-old male sustained an industrial injury on 1/28/08. Injury occurred while raking, lifting and carrying debris on wet grass and uneven surfaces. The patient reported onset of sharp right knee pain. The patient was status post right knee arthroscopy in September 2008 and August 2012. The 2/11/14 treating physician progress report documented a diagnosis of left knee sprain/strain secondary to compensation. The 4/14/14 treating physician report cited on-going grade 9/10 right knee pain. Bilateral knee physical exam findings documented normal range of motion. Right knee exam documented medial and lateral patellar facet tenderness, patellar tendon tenderness, medial joint line tenderness, and effusion. Left knee exam documented patellar tendon tenderness, medial and lateral joint line tenderness, effusion, and positive medial and lateral McMurray's. There was normal bilateral lower extremity strength, sensation, and reflexes. The diagnosis was right knee patellofemoral malalignment with excessive lateral patellar compression of the right lateral retinaculum and chondromalacia patella. The patient was deemed an excellent candidate for arthroscopic evaluation, arthroscopic chondroplasty and debridement of the right knee and lateral retinacular release. The treatment plan did not address the left knee. The 4/14/14 DWC form requested arthroscopic evaluation, arthroscopic chondroplasty and debridement of the LEFT knee and lateral retinacular release and associated services/durable medical equipment. The 6/6/14 utilization review denied the left knee surgery and associated requests as there was no documentation of radiographic malalignment consistent with guideline criteria.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopic Evaluation, Arthroscopic Chondroplasty and Debridement of the Left Knee and Lateral Retinacular Release.: 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).

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

**Decision rationale:** The California MTUS state that surgical consideration 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. Guideline criteria have not been met. There is no documentation that this patient has activity limitation relative to the left knee or has been afforded any conservative treatment to address the reported sprain/strain. This appears to be an erroneous request for LEFT knee surgery. The diagnosis documented right knee patellofemoral malalignment with excessive lateral patellar compression of the right lateral retinaculum and chondromalacia patella and compensatory left knee sprain/strain. There are no indications for left knee surgery based on clinical findings and there is no documentation of imaging findings. Therefore, this request for arthroscopic evaluation, arthroscopic chondroplasty and debridement of the left knee and lateral retinacular release is not medically necessary.

**Pre-Op Medical Clearance: 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).

**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: Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

**Decision rationale:** As the surgical request is not medically necessary, the associated request for pre-op medical clearance is also not medically necessary.

**Supervised Post-Op Rehabilitative Therapy, 3 x 4: 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).

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25.

**Decision rationale:** As the surgical request is not medically necessary, the associated request for supervised post-op rehabilitative therapy, 3 x 4 is also not medically necessary.

**Continuous Passive Motion for 14 Day: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Passive Motion.

**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 passive motion (CPM).

**Decision rationale:** As the surgical request is not medically necessary, the associated request for continuous passive motion for 14 day is also not medically necessary.

**Post-Op Surgi-Stim Unity for 90 Days:**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

**Decision rationale:** As the surgical request is not medically necessary, the associated request for post-op Surgi-Stim unit for 90 days is also not medically necessary

**Coolcare Cold Therapy Unity: 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).

**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:** As the surgical request is not medically necessary, the associated request for Coolcare cold therapy unit is also not medically necessary.