

Case Number:	CM14-0177955		
Date Assigned:	10/31/2014	Date of Injury:	06/16/2013
Decision Date:	04/02/2015	UR Denial Date:	10/20/2014
Priority:	Standard	Application Received:	10/27/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Orthopedic Surgery

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 31 year old female, who sustained an industrial injury on 6/16/2013. On 10/27/14, the injured worker submitted an application for IMR for review of Left knee arthroscopy and lateral release, and Associated surgical service: Post-op physical therapy x 12 for the left knee, and Associated surgical service: Cold therapy unit x 7 days. The treating provider has reported the injured worker complained of left knee pain taking over the counter medication to control pain. Exam note 9/16/14 demonstrates unchanged left knee symptoms. Moderate tenderness is noted over the patellofemoral joint. Normal flexion/extension is noted. Pain is described as anterior knee with catching with knee flexion. The diagnoses have included left knee strain/sprain, knee contusion, and effusion. Treatment to date has included x-ray left knee (6/17/13, MRI left knee (8/2/13), medication, knee brace, physical therapy. On 10/20/14 Utilization Review non-certified Left knee arthroscopy and lateral release, and Associated surgical service: Post-op physical therapy x 12 for the left knee, and Associated surgical service: Cold therapy unit x 7 days. The MTUS and ODG Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left knee arthroscopy and lateral release: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter, Chondroplasty, Lateral Retinacular Release, Current Concepts Review: Patellar Instability, Journal of Bone and Joint Surgery, December 2008, Volume 90-A Number 12, Pages 2751-2762.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg, Chondroplasty.

Decision rationale: CA MTUS/ACOEM is silent on the issue of chondroplasty. According to the ODG Knee and Leg regarding chondroplasty, Criteria include conservative care, subjective clinical findings of joint pain and swelling plus objective clinical findings of effusion or crepitus plus limited range of motion plus chondral defect on MRI. In this case the MRI from 8/2/13 does not demonstrate a clear chondral defect on MRI nor does the exam note demonstrate objective findings from 9/16/14 consistent with a symptomatic chondral lesion. Therefore the determination is for non-certification.

Associated surgical service: Post-op physical therapy x 12 for the left knee: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

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

Associated surgical service: Cold therapy unit x 7 days: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

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