

<b>Case Number:</b>	CM14-0194501		
<b>Date Assigned:</b>	12/02/2014	<b>Date of Injury:</b>	06/17/2013
<b>Decision Date:</b>	01/14/2015	<b>UR Denial Date:</b>	10/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/20/2014

### 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:

According to the records made available for review, this is a 33-year-old female with a 6/17/13 date of injury. At the time (10/1/14) of request for authorization for Arthroscopy left knee with chondroplasty, Associated surgical service: Pre-op medical clearance, Associated surgical service: Crutches (pair), Associated surgical services: Post op physical therapy to left knee (sessions) QTY: 12.00, and Associated surgical service: Cold therapy unit, there is documentation of subjective complaints of ongoing left knee pain with swelling and grinding, exacerbated by prolonged standing and walking, difficulty with kneeling and squatting, and intolerable pain when climbing stairs. Objective findings include antalgic gait, tenderness to palpation over the left knee medial joint line, positive McMurray's test, positive Clark's test, and decreased left knee flexion with crepitation. The imaging findings include an MRI of the left knee (3/3/14) report revealed meniscal degeneration but no meniscal tear. The current diagnoses include traumatic left knee internal derangement with degenerative tear of the medial meniscus, traumatic chondromalacia of patella, and traumatic synovitis of the left knee joint. Treatment to date includes medications, aquatic therapy, and steroid injection to left knee, home stretching exercises, and activity modification.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopy left knee with chondroplasty:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery - Chondroplasty; Criteria for Chondroplasty

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee, Chondroplasty

**Decision rationale:** MTUS reference to ACOEM guidelines state that referral for surgery may be indicated for patients who have: activity limitation for more than one month and failure of exercise programs to increase the range of motion and strength of the musculature around the knee. Official Disability Guidelines (ODG) identifies documentation of failure of conservative care (physical therapy or medications), subjective (joint pain AND swelling) and objective (effusion OR crepitus OR limited range of motion) findings, and imaging findings (Chondral defect on MRI), as additional criteria necessary to support the medical necessity of Chondroplasty. Within the medical information available for review, there is documentation of diagnoses of traumatic left knee internal derangement with degenerative tear of the medial meniscus, traumatic chondromalacia of patella, and traumatic synovitis of the left knee joint. In addition, there is documentation of activity limitation for more than one month and failure of exercise programs to increase the range of motion and strength of the musculature around the knee. There is documented failure of conservative care include aquatic therapy, medications, steroid injection to left knee, home stretching exercises, and activity modification. The subjective complaints include joint pain and swelling. The objective findings include crepitus and limited range of motion. The imaging findings are chondral defect on MRI. Therefore, based on guidelines and a review of the evidence, the request for Arthroscopy left knee with chondroplasty is medically necessary.

**Associated surgical service: Pre-op medical clearance:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Preoperative lab testing

**Decision rationale:** MTUS does not address this issue. Official Disability Guidelines (ODG) identifies that preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, and urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. Within the medical information available for review, there is documentation of diagnoses of traumatic left knee internal derangement with degenerative tear of the medial meniscus, traumatic chondromalacia of patella, and traumatic synovitis of the left knee joint. In addition, given documentation of an associated surgery has been found to be medically necessary, there is documentation that

preoperative testing can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management. Therefore, based on guidelines and a review of the evidence, this request is medically necessary.

**Associated surgical service: Crutches (pair):** Overturned

**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, Walking Aids (Canes, Crutches, Braces, Orthoses, & Walkers) and Non-MTUS Medicare National Coverage Determinations Manual.

**Decision rationale:** MTUS does not address this issue. Official Disability Guidelines (ODG) identifies documentation of disability, pain, and age-related impairments, as criteria necessary to support the medical necessity of a walking aid. Medical Treatment Guidelines identifies documentation of a personal mobility deficit sufficient to impair the patient's participation in mobility-related activities of daily living in customary locations within the home, as criteria necessary to support the medical necessity of crutches. Within the medical information available for review, there is documentation of diagnoses of traumatic left knee internal derangement with degenerative tear of the medial meniscus, traumatic chondromalacia of patella, and traumatic synovitis of the left knee joint. In addition, given documentation of an associated surgery has been found to be medically necessary, there is documentation of an intention to treat a personal mobility deficit sufficient to impair the patient's participation in mobility-related activities of daily living in customary locations within the home. Therefore, based on guidelines and a review of the evidence, this request is medically necessary.

**Associated surgical services: Post op physical therapy to left knee (sessions) QTY: 12.00:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24-25.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

**Decision rationale:** MTUS Postsurgical Treatment Guidelines identifies up to 12 visits of post-operative physical therapy over 12 weeks and post-surgical physical medicine treatment period of up to 6 months. In addition, MTUS Postsurgical Treatment Guidelines identifies that the initial course of physical therapy following surgery is 1/2 the number of sessions recommended for the general course of therapy for the specified surgery. Within the medical information available for review, there is documentation of diagnoses of traumatic left knee internal derangement with degenerative tear of the medial meniscus, traumatic chondromalacia of patella, and traumatic synovitis of the left knee joint. However, despite documentation of an associated request for left knee arthroscopy with chondroplasty that has been found to be medically

necessary, the requested amount of postoperative physical therapy sessions exceeds guidelines (for an initial course of physical therapy following surgery). Therefore, based on guidelines and a review of the evidence, this request is not medically necessary.

**Associated surgical service: 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)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter, Continuous-Flow Cryotherapy

**Decision rationale:** MTUS does not address this issue. Official Disability Guidelines (ODG) identifies that continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use. Within the medical information available for review, there is documentation of diagnoses of traumatic left knee internal derangement with degenerative tear of the medial meniscus, traumatic chondromalacia of patella, and traumatic synovitis of the left knee joint. However, despite documentation of an associated request for left knee arthroscopy with chondroplasty that has been found to be medically necessary, there is no documentation of the proposed duration of therapy with the requested Cold therapy unit. Therefore, based on guidelines and a review of the evidence, the request for the cold therapy unit is not medically necessary.