

Case Number:	CM14-0201553		
Date Assigned:	12/11/2014	Date of Injury:	02/25/2010
Decision Date:	02/17/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/02/2014

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:

The injured worker is a 50-year-old male who reported an injury on 02/25/2010. His diagnoses include degenerative lumbar disc disease, chondromalacia of the patella, osteoarthritis of the lower leg, spinal stenosis of lumbar, chondromalacia of the tibia, a tear in the medial meniscus, lumbar sprain/strain, sciatica, sprain/strain of the cruciate ligament, sprain/strain of the knee or leg, loose body in the knee and a tear in the lateral meniscus. Past therapies include medication, physical therapy and injections. Pertinent diagnostic studies include a right knee MRI, performed on 10/13/2014, which revealed a horizontal cleavage tear of the body of the lateral meniscus extending into the lateral aspect of the posterior horn of the medial meniscus. Interval progression of cystic degeneration of the ACL with intraligamentous ganglia increasingly expanding the ligament and increased intraosseous extension of pain into the anterior tibial spine, tricompartmental osteoarthritis progressed from prior most advanced in the lateral compartment demonstrating grade IV chondromalacia. Grade III chondromalacia of the medial femoral patellar compartments. Moderate joint effusion increased from prior injury. A moderate sized Baker's cyst enlarged compared to prior with intra-articular body again noted in the anterior intercondylar notch possibly sequestered in the infrapatellar cleft. His pertinent surgical history was not provided. On 09/23/2014, the injured worker complained of chronic back pain that radiates into the lower extremities, along with bilateral knee pain. The physical examination revealed a positive straight leg raise bilaterally. Motor exam was felt to be normal in all lower extremities and intact to sensation, muscle strength and reflexes. His medication included hydrocodone. The treatment plan included Right knee subchondroplasty, arthroscopic debridement, CPM rental 21 days, Outpatient physical therapy 3 times per week for 4 weeks and Polar care unit. The rationale for the request was not provided. The Request for Authorization form was received 11/13/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right knee subchondroplasty, arthroscopic debridement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines Knee chapter Subchondroplasty

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 and Leg, Subchondroplasty.

Decision rationale: The request for Right knee subchondroplasty, arthroscopic debridement is not medically necessary. According to the California MTUS/ACOEM Guidelines, surgical considerations are indicated for patients who have activity limitations for more than 1 month and failure of exercise programs to increase range of motion and strength of the musculature around the knee. In addition, more specifically, the Official Disability Guidelines indicate that subchondroplasty is not recommended. There is no support for its use for full thickness chondral defects or joint space narrowing and osteoarthritis. The injured worker was indicated to have bilateral knee pain. However, the documentation failed to provide evidence in regard to the injured worker's activity limitation that was beyond 1 month and failure of exercise programs to increase range of motion and strength of the musculature around the knee. In addition, the guidelines do not recommend subchondroplasty. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Continuous Passive Motion (CPM) rental 21 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 339. Decision based on Non-MTUS Citation Official Disability Guidelines Knee and leg chapter

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: The request for CPM rental 21 days is not medically necessary. According to the Official Disability Guidelines, the criteria for use would include 4 to 10 consecutive days with a max of 21 days for postoperative use for the following procedures to include total knee arthroplasty, anterior cruciate ligament reconstruction, or open reduction internal fixation of the tibial plateau or distal femur fractures. However, the guidelines indicate it may be indicated for home use for up to 17 days after surgery for patients at risk of a stiff knee or are immobile or unable to bear weight following low postoperative mobility or inability to comply with rehabilitation exercises following a total knee arthroplasty to include complex regional pain syndrome, extensive arthrofibrosis or tendon fibrosis, or physical, mental, behavioral inability to participate in active physical therapy. The patient was indicated to undergo a right knee subchondroplasty and arthroscopic debridement. However, there is lack of documentation to

indicate the patient would need it for total knee arthroplasty, anterior cruciate ligament reconstruction, or open reduction internal fixation of the tibial plateau or distal femur fractures involving the knee joint. In addition, the request exceeds the days recommended by the guidelines of 4 to 10 consecutive days, with a max of 21. Based on the above, the request is not medically necessary.

Physical therapy 3 times per week for 4 weeks: Upheld

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

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

Decision rationale: The request for Outpatient physical therapy 3 times per week for 4 weeks is not medically necessary. According to the California MTUS Post-surgical Guidelines, procedures for the old bucket handle tear, derangement of meniscus, loose body in knee, chondromalacia of patella or tibialis tendonitis may be allotted 12 physical therapy visits post surgically. However, the concurrent right knee surgery request is not supported. As such, the current request for Outpatient physical therapy 3 times per week for 4 weeks is also not supported. As such, the request is not medically necessary.

Polar care 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), Continuous-flow cryotherapy

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: The request for Polar care unit is not medically necessary. According to the Official Disability Guidelines, continuous flow cryotherapy units are recommended post surgically for up to 7 days, including home use. There is lack of documentation to indicate the patient had medical necessity for the continuous cryotherapy unit. The concurrent surgical request was not supported by the guidelines. As such, the current request is also not supported. In addition, the request failed to specify the number of days for postoperative use. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.