

<b>Case Number:</b>	CM14-0216373		
<b>Date Assigned:</b>	02/04/2015	<b>Date of Injury:</b>	02/05/2010
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	11/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/24/2014

### 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: New York

Certification(s)/Specialty: Neurological 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 64 year old female, who sustained an industrial injury on 2/5/10. The PR2 on 8/28/14 noted that the injured worker has complaints of right shoulder and left knee pain. She reports her right shoulder symptoms has been managing doing her home exercise program and trying to maintain range of motion and that her left knee has constant pain aggravated with going up and down stairs. The injured worker was given a cortisone shot in the knee for symptoms management. Magnetic Resonance Imaging (MRI) 5/30/14 confirms medial compartment cartilage wear and medial meniscus tear. The assessment noted that the injured worker had a history of right shoulder pain with slap lesion and left knee pain with history of chondromalacia and medial meniscus tear, now suspicious for loose body. According to the utilization review performed on 11/26/14, the requested Left knee scope debridement, chondral meniscal; Norco 10-325mg #60; Pre-op clearance: H&P, EKG, labs; Post-op physical therapy, 3 times a week for 8 weeks for left knee; Post-op crutches; Post-op Game ready cryo unit (14-day rental) ; Keflex 500mg #28; Phenergan 25mg #30; Ibuprofen 600mg #90 and Percocet 10-325mg #60 has been non-certified. CA MTUS, the CA MTUS Chronic Pain Medical Treatment Guidelines was referenced regarding Norco; the ODG knee and leg chapter; CA MTUS Postsurgical Treatment Guidelines; ODG Infectious Diseases Chapter; ODG Pain chapter; CA MTUS Chronic Pain Medical Treatment Guidelines; ACOEM Practice Guidelines 2nd edition (2004) and American Academy of Orthopedic Surgeons were used in the utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left knee scope debridement, chondral meniscal: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338,339.

**Decision rationale:** The California MTUS guidelines indicate that exercises should be taught the patient for managing her range of motion and increasing strength. Details of such education are not provided as are instructions for time and frequency. Documentation is not provided about range of motion and the patient's strength. Documentation is not provided about the symptoms of clear evidence for a meniscus tear. Thus the requested treatment: left knee scope debridement, chondral meniscal is not medically necessary and appropriate.

**Norco 10-325mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-going management Page(s): 78, 80.

**Decision rationale:** The California MTUS guidelines indicate that opioids are not recommended as first line treatment for osteoarthritis. Documentation does not indicate whether there was a failure of a trial with first-line medication. Guidelines indicate that the lowest possible dose to improve pain and function is advised. Documentation does not indicate that ongoing review and documentation of the functional status, pain relief and appropriate medication use is continuing or that the 4 A's for ongoing monitoring is being followed. Thus the requested treatment: Norco 10-325mg #60 is not medically necessary and appropriate.

**Associated surgical service: Pre-op clearance: H&P, EKG, labs: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Orthopaedic Surgeons.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: left knee scope debridement, chondral meniscal is not medically necessary and appropriate, then the Requested Treatment: Pre-op clearance: H&P, EKG, labs is not medically necessary and appropriate.

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

**Associated surgical service: Post-op physical therapy, 3 times a week for 8 weeks for left knee:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: left knee scope debridement, chondral meniscal is not medically necessary and appropriate, then the Requested Treatment: Post-op physical therapy, 3 times a week for 8 weeks for left knee is not medically necessary and appropriate.

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

**Associated surgical service: Post-op crutches:** 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), Knee & Leg Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: left knee scope debridement, chondral meniscal is not medically necessary and appropriate, then the Requested Treatment: Post-op crutches is not medically necessary and appropriate.

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

**Associated surgical service: Post-op Game ready cryo unit (14-day rental):** 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), Knee & Leg Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: left knee scope debridement, chondral meniscal is not medically necessary and appropriate, then the Requested Treatment: Post-op Game ready cryo unit (14-day rental) is not medically necessary and appropriate.

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

**Keflex 500mg #28:** 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 Since the requested treatment: left knee scope debridement, chondral meniscal is not medically necessary and appropriate, then the Requested Treatment: Keflex 500 mg #28 is not medically necessary and appropriate.

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

**Phenergan 25mg #30:** 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), Pain Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: left knee scope debridement, chondral meniscal is not medically necessary and appropriate, then the Requested Treatment: Phenergan 25mg #30 is not medically necessary and appropriate.

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

**Ibuprofen 600mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: left knee scope debridement, chondral meniscal is not medically necessary and appropriate, then the Requested Treatment: Ibuprofen 600mg #90 is not medically necessary and appropriate.

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

**Percocet 10-325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids-on-going management Page(s): 78-80.

**Decision rationale:** The California MTUS guidelines indicate that opioids are not recommended as first line treatment for osteoarthritis. Documentation does not indicate whether there was a failure of a trial with first-line medication. Guidelines indicate that the lowest possible dose to improve pain and function is advised. Documentation does not indicate that ongoing review and documentation of the functional status, pain relief and appropriate medication use is continuing or that the 4 A's for ongoing monitoring is being followed. Thus the requested treatment: Percocet 10-325mg #60 is not medically necessary and appropriate.