

Case Number:	CM14-0040059		
Date Assigned:	06/27/2014	Date of Injury:	06/11/2010
Decision Date:	05/12/2015	UR Denial Date:	03/25/2014
Priority:	Standard	Application Received:	04/04/2014

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: Illinois, California, Texas
 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 36-year-old male who sustained an industrial injury on 6/11/10. The mechanism of injury was not documented. Past medical history was positive for borderline hypertension. Past surgical history was positive for multiple left knee surgeries. The injured worker underwent diagnostic arthroscopy of the right knee with chondroplasty of the femoral groove, partial medial meniscectomy, patelloplasty, partial synovectomy, removal of loose bodies, and autologous chondrocyte implantation on 6/10/13. The 10/28/13 and 12/12/13 bilateral knee x-rays showed no progression of bilateral knee and tibia osteoarthritis. The 3/10/14 treating physician report indicated that the injured worker was doing much better with decreased swelling. Diagnosis included a large osteochondral defect of the femoral groove of the right knee. Phase two of the autologous chondrocyte implantation was recommended to fill in the large osteochondral defect. The 3/25/14 utilization review non-certified the request for right knee diagnostic arthroscopy with autologous chondrocyte implantation, femoral groove and associate surgical requests for post-operative physical therapy 3 times per week for 4 weeks, and medical clearance, CBC, CMP, PT/PTT, and UA. The rationale for non-certification of surgery and associated requests indicated that the injured worker had patellofemoral articular cartilage pathology that was an exclusion for treatment with autologous chondrocyte implantation of the knee. The 4/24/14 treating physician report cited complaints of right knee pain, stiffness, swelling, tenderness, decreased range of motion, and limping. Functional difficulty was documented in activities of daily living and work duties. Authorization was request for autologous chondrocyte implantation. The 6/17/14 utilization review certified the request for

right knee diagnostic arthroscopy with autologous chondrocyte implantation, femoral groove on appeal.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative Physical Therapy, 3x week for 4 weeks qty 12: Overturned

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 California Post-Surgical Treatment Guidelines for surgery for chondral lesions suggest a general course of 12 post-operative visits over 12 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 6 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. This is the initial request for post-operative physical therapy and, although it exceeds recommendations for initial care, is within the recommended general course. Therefore, this request for is medically necessary.

Medical Clearance, CBC, CMP, PT/PTT, UA per 3/18/14 qty 1: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for pre-anesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Pre-anesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Guideline criteria have been met based on past medical history and the risks of undergoing anesthesia. Therefore, this request is medically necessary.