

<b>Case Number:</b>	CM15-0000260		
<b>Date Assigned:</b>	01/09/2015	<b>Date of Injury:</b>	06/04/2008
<b>Decision Date:</b>	03/17/2015	<b>UR Denial Date:</b>	12/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/02/2015

### 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 47 year old female teacher sustained an injury on 06/04/2008. Mechanism is not described. On the PR2 of 08/12/14 she noted she had gone on a teaching tour and walked 5-6 miles a day and was having pain in her right knee. Increased medial joint pain with an effusion and crepitation with range of motion of the knee was noted. The injured worker was diagnosed with degenerative joint disease. The PR2 of 5/27/2014 noted the complaint of increased pain in the knee, medially, swelling and range of motion 0-110 degrees. Quadriceps muscle strength was normal. The medial McMurray's test was positive as was the bounce test. Old x-rays were noted to show mild to moderate degenerative joint disease and an MRI was ordered. The note of 08/12/2014 stated there was cartilaginous injury but no meniscal injury noted on the MRI. Physical therapy was recommended and a request for Orthovisc injection series, and request for injection under ultrasound guidance. The PR2 of 11/17/2014 noted the injured worker complained of continued right knee pain with catching and locking with range of motion 0-100 and strength 4/5. The treating physician requested arthroscopic possible meniscectomy to the right knee, chondroplasty to the right knee, abrasion arthroplasty to the right knee, synovectomy to the right knee and related post-operative treatments for debridement of articular cartilage problem. On 12/16/2014, Utilization Review non-certified the prescriptions for arthroscopic possible meniscectomy to the right knee, chondroplasty to the right knee, abrasion arthroplasty to the right knee, synovectomy to the right knee, post-operative physical therapy twice weekly to the right knee with a quantity of twelve, and cold therapy unit seven day rental or purchase, noting the CA MTUS Guidelines, Postsurgical Treatment Guidelines Pages 24-25; ACOEM

Guidelines , Knee Complaints; and Official Disability Guidelines, Knee & Leg (updated 10/27/2014) was cited.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Arthroscopic possible meniscectomy, right knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for Surgery - Meniscectomy, Knee & Leg

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-5. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Knee Chapter and Knee Replacement Chapter

**Decision rationale:** Rationale: According to California MTUS guidelines ( Knee Chapter p344-345) consistent findings on the MRI scan and severe limitation of activity are advised to proceed with arthroscopic meniscectomy. Caution is advised when the worker has signs of degenerative change as the outcome from surgery may not be beneficial. According to ODG Guidelines (Knee Chapter) criteria for approval of a requested arthroscopic meniscectomy, includes a positive MRI scan. This injured worker's MRI specifically said there was no meniscus tear. ODG guidelines further do not recommend subchondroplasty, or focal joint resurfacing in the absence of high quality imaging studies. Chondroplasty is not recommended in patients with osteoarthritis unless the injured worker has failed an optimized medicine and physical therapy program and there is evidence of chondral defect on the MRI scan. Evidence has not been provided in the documentation that this is the case. Moreover, arthroplasty criteria recommends the worker be over age fifty and have documented significant loss of the chondral clear space. The worker is 46 and such loss of the chondral clear space is not substantiated. Documentation is not provided about where synovectomy would be accomplished and what studies objectively document it's necessity.

#### **Chondroplasty, right knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for Surgery - Chondroplasty, Knee & Leg

**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 and Knee Replacement Chapter

**Decision rationale:** Rationale: According to California MTUS guidelines ( Knee Chapter p344-345) consistent findings on the MRI scan and severe limitation of activity are advised to proceed with arthroscopic meniscectomy. Caution is advised when the worker has signs of degenerative change as the outcome from surgery may not be beneficial. According to ODG Guidelines (Knee

Chapter) criteria for approval of a requested arthroscopic meniscectomy, includes a positive MRI scan. This injured worker's MRI specifically said there was no meniscus tear. ODG guidelines further do not recommend subchondroplasty, or focal joint resurfacing in the absence of high quality imaging studies. Chondroplasty is not recommended in patients with osteoarthritis unless the injured worker has failed an optimized medicine and physical therapy program and there is evidence of chondral defect on the MRI scan. Evidence has not been provided in the documentation that this is the case. Moreover, arthroplasty criteria recommends the worker be over age fifty and have documented significant loss of the chondral clear space. The worker is 46 and such loss of the chondral clear space is not substantiated. Documentation is not provided about where synovectomy would be accomplished and what studies objectively document it's necessity.

**Abrasion arthroplasty, right knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for Surgery - Knee arthroplasty, Knee & Leg

**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, Knee Replacement Chapter

**Decision rationale:** Rationale: According to California MTUS guidelines ( Knee Chapter p344-345) consistent findings on the MRI scan and severe limitation of activity are advised to proceed with arthroscopic meniscectomy. Caution is advised when the worker has signs of degenerative change as the outcome from surgery may not be beneficial. According to ODG Guidelines (Knee Chapter) criteria for approval of a requested arthroscopic meniscectomy, includes a positive MRI scan. This injured worker's MRI specifically said there was no meniscus tear. ODG guidelines further do not recommend subchondroplasty, or focal joint resurfacing in the absence of high quality imaging studies. Chondroplasty is not recommended in patients with osteoarthritis unless the injured worker has failed an optimized medicine and physical therapy program and there is evidence of chondral defect on the MRI scan. Evidence has not been provided in the documentation that this is the case. Moreover, arthroplasty criteria recommends the worker be over age fifty and have documented significant loss of the chondral clear space. The worker is 46 and such loss of the chondral clear space is not substantiated. Documentation is not provided about where synovectomy would be accomplished and what studies objectively document it's necessity.

**Synovectomy, right knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/15002354>

**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, Knee Replacement Chapter

**Decision rationale:** Documentation is not provided about where synovectomy would be accomplished and what studies objectively document it's necessity. As noted in the Utilization Review denial it is a formidable procedure for the whole knee. The MRI scan is not quoted in the documentation as showing pathology which would require consideration for this invasion. Indeed, the ODG guidelines do not include criteria for such an operation in lieu of total knee arthroplasty which criteria she does not meet.

**Associated surgical service: Postoperative physical therapy, twice weekly, right knee QTY: 12.00:** Upheld

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

**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, 7-day rental or purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg, Continuous-flow cryotherapy

**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.