

Case Number:	CM15-0015902		
Date Assigned:	03/09/2015	Date of Injury:	06/14/2013
Decision Date:	04/21/2015	UR Denial Date:	01/14/2015
Priority:	Standard	Application Received:	01/27/2015

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: 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 48-year-old female who sustained an industrial injury on 6/14/13. Injury occurred when a child pulled a piece of cardboard from under her feet, causing her to fall on both knees. Conservative treatment for the left knee included physical therapy, medications, corticosteroid injections, Supartz injections, and activity modification. The 12/17/13 left knee MRI impression documented grade I-II degenerative signal in the posterior horn of the medial meniscus with no evidence of a meniscal tear, and moderate to severe chondromalacia patellae with subchondral marrow signal abnormality in the patella. There were no definite osteochondral defects seen. The 12/11/2014 treating physician cited constant bilateral knee pain, left greater than right, radiating into her left calf and foot. Associated symptoms included burning, popping, locking, and swelling of both knees, and frequent giving way. Difficulty was noted with sitting, standing, walking, prolonged driving, sleeping, and with lifting anything while going up and down stairs. Physical exam documented focal tenderness over the left knee medial compartment and posterior horn of the medial meniscus. There was moderate tenderness of the patellofemoral joint and lateral patellar facet. Range of motion was 0-130 degrees with a questionably positive medial McMurray's test. There was no instability. MRI review noted at least a 1x1 cm patella osteochondral defect, and a grade II, possibly grade III, undersurface tear of the medial meniscus not identified on the MRI report. The diagnosis was left knee severe chondromalacia of the superior pole of the patella with osteochondral defect and questionable medial meniscus tear, and left knee internal derangement. The patient had two left knee corticosteroid injections and a series of Supartz. She was limited in her use of anti-inflammatories due to gastritis.

Authorization was requested for diagnostic left knee video arthroscopy with possible medial meniscectomy and chondroplasty of the medial superior pole of the patella. The 1/14/15 utilization review non-certified a request for diagnostic left knee video arthroscopy with possible medial meniscectomy and chondroplasty of the medial superior pole of the patella, and associated surgical services including: cold therapy unit, crutches, neoprene sleeve slip on brace; post-op knee brace, physical therapy 12 sessions, pre-op chest x-ray and EKG; and pre-op labs: CBC, PT/PTT, electrolytes, BUN, UA, and Chem 7. The rationale for non-certification cited a lack of detailed documentation of physical therapy treatment and response. The Medical Treatment Utilization Schedule and Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diagnostic left knee video arthroscopy with possible medial meniscectomy and chondroplasty of the medial superior pole of the patella, per 12/15/14 form: Overturned

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

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: Chondroplasty; Meniscectomy.

Decision rationale: The California MTUS guidelines state that surgical consideration may be indicated for patients who have activity limitation for more than one month and failure of exercise programs to increase range of motion and strength of the musculature around the knee. Guidelines support arthroscopic partial meniscectomy for cases in which there is clear evidence of a meniscus tear including symptoms other than simply pain (locking, popping, giving way, and/or recurrent effusion), clear objective findings, and consistent findings on imaging. The Official Disability Guidelines criteria for meniscectomy include conservative care (exercise/physical therapy and medication or activity modification) plus at least two subjective clinical findings (joint pain, swelling, feeling or giving way, or locking, clicking or popping), plus at least two objective clinical findings (positive McMurray's, joint line tenderness, effusion, limited range of motion, crepitus, or locking, clicking, or popping), plus evidence of a meniscal tear on MRI. The ODG criteria for chondroplasty include evidence of conservative care (medication or physical therapy), plus joint pain and swelling, plus effusion or crepitus or limited range of motion, plus a chondral defect on MRI. Guideline criteria have been met. This patient presents with persistent left knee pain with symptoms of popping, locking, swelling, and frequent giving way. Clinical exam findings are consistent with imaging findings of a patellar chondral defect and plausible meniscal tear. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Pre-Op labs: CBC, PT/PTT, lytes, BUN, UA, Chem 7 per 12/15/14 form: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back, Preoperative lab testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia 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 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 patient age, long-term use of non-steroidal anti-inflammatory drugs, history of gastritis, and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

Pre-Op Chest x-ray and EKG per 12/15/14 form: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back, preoperative testing, general.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia 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 state that routine pre-operative chest radiographs are not recommended except when acute cardiopulmonary disease is suspected on the basis of history and physical examination. Guidelines state that an EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. Middle aged males have known occult increased medical/cardiac risk factors that support the medical necessity of these pre-procedure tests. Therefore, this request is medically necessary.

Post-op Physical Therapy, 12 sessions of unspecified frequency for the left knee, per 12/15/14 form: Overturned

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): 25.

Decision rationale: The California Post-Surgical Treatment Guidelines for chondroplasty and meniscectomy 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 is medically necessary.

Associated surgical service: Crutches per 12/15/14 form: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee & Leg, Walking aids.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338-340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: The California MTUS guidelines support the use of crutches for partial weight bearing for patients with knee complaints. The Official Disability Guidelines state that disability, pain, and age-related impairments determine the need for a walking aid. Assistive devices can reduce pain and allow for functional mobility. The post-operative use of crutches is consistent with guidelines. Therefore, this request is medically necessary.

Post-op knee brace, per 12/15/14 form: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee and Leg, Knee Brace.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Knee braces.

Decision rationale: The California MTUS does not provide recommendations for post-operative knee braces. The Official Disability Guidelines support the use of pre-fabricated braces for the following conditions: knee instability, ligament insufficiency/deficiency, reconstructed ligament, articular defect repair, avascular necrosis, meniscal cartilage repair, painful failed total knee arthroplasty, painful high tibial osteotomy, painful unicompartmental osteoarthritis, or tibial plateau fracture. The use of a post-operative knee brace for pain control and support is consistent with guidelines. Therefore, this request for is medically necessary.

Associated surgical service: Neoprene sleeve slip on brace, per 12/15/14 form: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee and Leg, Knee brace.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Knee braces.

Decision rationale: The California MTUS does not provide recommendations for post-operative knee sleeves. The Official Disability Guidelines support the use of a post-op knee brace for this patient, which has been requested and found medically necessary. There is no compelling reason to support the medical necessity of a neoprene sleeve for this patient in addition to the knee brace. Therefore, this request is not medically necessary.

Associated surgical service: Cold therapy unit, per 12/15/14 form: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee and Leg, 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 California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after knee surgery for up to 7 days. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request is not medically necessary.