

<b>Case Number:</b>	CM15-0147344		
<b>Date Assigned:</b>	08/10/2015	<b>Date of Injury:</b>	01/03/2014
<b>Decision Date:</b>	09/04/2015	<b>UR Denial Date:</b>	07/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/29/2015

### 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: California, Oregon, Washington  
 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 35 year old male, who sustained an industrial injury on 1-03-2014. Diagnoses include left knee magnetic resonance imaging (MRI) confirmed medial meniscal tear. Treatment to date has included conservative treatment including modified work, diagnostics, medications and shockwave therapy. Per the Primary Treating Physician's Progress Report dated 4-28-2015 the injured worker reported bilateral knee pain left greater then right with popping and giving way. Physical examination of the bilateral knees revealed tenderness to palpation over the medial and lateral joint lines and parapatellar regions, left side greater than right. The plan of care included surgical intervention and authorization was requested for arthroscopic left knee medial meniscectomy chondroplasty and debridement, preoperative medical clearance, one cool- care cold therapy unit, one pair of crutches, one post-operative knee brace, 12 sessions of supervised post-operative rehabilitative therapy, 14 days of continuous passive motion (CPM) device and 90 days of surgi-stim unit

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 Sessions of Supervised Post-Op Rehab Therapy: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

**Decision rationale:** According to the CA MTUS/Post Surgical Treatment Guidelines, Knee Meniscectomy, page 24, 12 visits of therapy are recommended after arthroscopy with partial meniscectomy over a 12-week period. The guidelines recommend initially of the 12 visits to be performed. As the request exceeds the initial allowable visits, the determination is for non-certification. The request is not medically necessary.

**Associated Surgical Service: 14 Days of Continuous Passive Motion Device:** 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 Official Disability Guidelines (ODG) Knee.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of CPM after knee arthroscopy. According to ODG criteria, CPM is medically necessary post-operatively for 4-10 consecutive days but no more than 21 following total knee arthroplasty. As the guideline criteria have not been met the determination is for non-certification. The request is not medically necessary.

**Associated Surgical Service: 90 Days of Surgi-Stim 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).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

**Decision rationale:** Regarding the Interferential Current Stimulation (ICS), the California MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation, pages 118-119 state, "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. "As there is insufficient medical evidence regarding use in this clinical scenario, the determination is for non-certification. The request is not medically necessary.