

<b>Case Number:</b>	CM15-0182727		
<b>Date Assigned:</b>	09/30/2015	<b>Date of Injury:</b>	05/14/2014
<b>Decision Date:</b>	12/10/2015	<b>UR Denial Date:</b>	08/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2015

### 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, Indiana, Oregon  
 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 22 year old male, who sustained an industrial-work injury on 5-14-14. A review of the medical records indicates that the injured worker is undergoing treatment for right knee medial meniscus tear, low back pain and extruded disc of the lumbar spine. Medical records dated 7-30-15 indicate that the injured worker complains of right knee pain and low back pain. Per the treating physician report dated 5-28-15 the work status is temporarily totally disabled. (OBJ) The physical exam dated 7-30-15 reveals positive tenderness in the posterior superior iliac spine, there is decreased lumbar range of motion due to pain, and positive straight leg raise bilaterally. The right knee exam reveals positive medial joint line tenderness and, positive McMurray's test. Treatment to date has included diagnostics, chiropractic, and physical therapy at least 12 sessions, rest, off of work and other modalities. Magnetic resonance imaging (MRI) of the right knee dated 7-28-14 reveals abnormality of the posterior horn of the medial meniscus representing a tear and abnormality of the lateral meniscus representing a tear. The Magnetic Resonance Imaging (MRI) of the lumbar spine dated 8-9-14 reveals L4-L5 disc level shows dehiscence of the nucleus pulposus with a 7 millimeter downward extrusion. The requested services included Arthroscopy and partial medial meniscectomy right knee, Post-op physical therapy, 3 times weekly for 6 weeks, associated surgical service: Vascutherm unit, Lumbar epidural steroid injection (ESI) x 2 with pain management, Spine surgery consultation for a possible lumbar discectomy, Preoperative internal medicine evaluation, Diclofenac XR #120 and Omeprazole 20 mg #120. The original Utilization review dated 8-20-15 non-certified the request for Arthroscopy and partial medial meniscectomy right knee, Post-op physical

therapy, 3 times weekly for 6 weeks, Associated surgical service: Vascutherm unit, Lumbar epidural steroid injection (ESI) x 2 with pain management, Spine surgery consultation for a possible lumbar discectomy, Preoperative internal medicine evaluation, Diclofenac XR #120 and Omeprazole 20 mg #120

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

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

**Arthroscopy and partial medial meniscectomy right knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004.

**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:** CAMTUS/ACOEM Chapter 13 Knee Complaints, pages 344-345, states regarding meniscus tears, "Arthroscopic partial meniscectomy usually has a high success rate for cases in which there is clear evidence of a meniscus tear-symptoms other than simply pain (locking, popping, giving way, recurrent effusion)." According to ODG Knee and Leg section, Meniscectomy section, states indications for arthroscopy and meniscectomy include attempt at physical therapy and subjective clinical findings, which correlate with objective examination and MRI. In this case the exam notes do not demonstrate evidence of adequate course of physical therapy or other conservative measures. In addition there is lack of evidence in the cited records of meniscal symptoms such as locking, popping, giving way or recurrent effusion. Therefore the request is not medically necessary.

**Post-op physical therapy, 3 times weekly for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 2009.

**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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated surgical service: Vascutherm 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:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) knee.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Lumbar ESI x 2 with pain management:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back.

**Decision rationale:** According to the CA MTUS Chronic Pain Medical Treatment Guidelines, page 46, "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." Specifically the guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In addition there must be demonstration of unresponsiveness to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case the exam notes cited do not demonstrate a failure of conservative management nor a clear evidence of a dermatomal distribution of radiculopathy. Therefore the request is not medically necessary.

**Spine surgery consultation for a possible lumbar discectomy:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** CA MTUS/ACOEM guidelines, low back complaints, page 288 recommends referral for clear clinical imaging and electrodiagnostic evidence of a lesion shown to benefit from surgical repair. There is no evidence in the cited records of significant and specific nerve root compromise or confirmed diagnostic study to warrant referral to a neurosurgeon or specialist. Therefore the cited guidelines criteria have not been met and the request is not medically necessary.

**Preoperative internal medicine evaluation:** Upheld

**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 Official Disability Guidelines (ODG) knee.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Diclofenac XR #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

**Decision rationale:** Per the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 66 states that diclofenac is a non-steroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. It is used as first line treatment but long-term use is not warranted. In this case the continued use of diclofenac is not warranted, as there is no demonstration of functional improvement and the injury is no longer acute. Therefore the request is not medically necessary.

**Omeprazole 20 mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** Per the CA MTUS Chronic Pain Medical Treatment Guidelines, page 68, recommendation for Prilosec is for patients with risk factors for gastrointestinal events. The cited records do not demonstrate that the patient is at risk for gastrointestinal events. Therefore the request is not medically necessary.