

Case Number:	CM15-0034278		
Date Assigned:	02/27/2015	Date of Injury:	09/15/2013
Decision Date:	04/22/2015	UR Denial Date:	02/19/2015
Priority:	Standard	Application Received:	02/23/2015

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 54-year-old female who sustained a work related injury on 9/15/13, when she slipped and fell injuring both her knees. Records indicated the patient had undergone physiotherapy, chiropractic, and acupuncture treatment. The 11/24/14 orthopedic consult report cited grade 8/10 bilateral knee pain. Left knee exam documented medial joint line tenderness, effusion, medial crepitus, patellar crepitus, and positive medial McMurray's test. Range of motion was 0-120 degrees, and strength was normal. An ultrasound study on 4/23/14 showed left medial meniscus tear and right medial compartment degenerative joint disease. The patient had failed conservative treatment, including supervised physical therapy, home exercise program, activity modification, and anti-inflammatory medications. The patient was an excellent candidate for left knee arthroscopy with left partial meniscectomy, chondroplasty, and debridement. The 12/11/14 medical legal report cited occasional sharp bilateral knee pain, more so on the left. She complained of numbness, swelling, tingling, weakness, clicking, grinding, and popping sensations. Pain increased with standing more than 30 minutes. She had buckling and giving way of the knees, worse on the right. Physical exam documented varus alignment of the lower extremities, antalgic gait, no swelling, and patellar crepitus and retro patellar tenderness in both knees with firm palpation. There was bilateral medial joint line tenderness, no instability, and negative McMurray's, Lachman's, anterior drawer, posterior say, and knee jerk. The diagnosis included degenerative arthritis, both knees. The treatment plan recommended viscosupplementation injections for both knees. The 12/24/14 treating physician report cited a flare-up of symptoms this week, which improved with hydrocodone. Physical exam documented

lumbosacral paraspinal tenderness with spasms, and positive mechanical and nerve tension signs. Bilateral knee exam documented tenderness, right greater than left. Range of motion was 0-130 degrees bilaterally, and pain with medial McMurray's bilaterally. The patient wanted to think over surgical options and felt she could manage symptoms with medications and activity modification. The 2/19/15 utilization review non-certified a request for an left knee arthroscopic evaluation, partial medial meniscectomy, chondroplasty and debridement, a request for medical clearance to include a two night home sleep study to rule out sleep apnea; supervised post-operative rehabilitative therapy; three times per week for four weeks; continuous passive motion device for an initial period of fourteen days; Surgi-Stim unit for an initial period of ninety days; and Cool Care cold therapy unit. The American College of Occupational and Environmental Medicine Guidelines and California Medical Treatment Utilization Schedule Guidelines were cited. The rationale noted the patient had extensive arthritis and the meniscal tear was also likely degenerative in nature which is not supported by guidelines, and there was no rationale why injection therapy would not be trialed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic Evaluation, Arthroscopic Left Partial Medial Meniscectomy, Chondroplasty and Debridement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Chapter, Diagnostic Arthroscopy, Indications for Surgery -- Diagnostic Arthroscopy.

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.

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 MRI. The Official Disability Guidelines 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 not been met. This patient presents with bilateral knee pain with giving way, buckling, and clicking, grinding, and popping sensations. Physical exam findings were generally consistent with medial meniscus tear and chondromalacia patella. However, there is no MRI evidence of meniscal tear and chondral defect documented in the available records to support the medical necessity of this surgical request. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

Pre-Operative Medical Clearance (to include a two-night home sleep study polysomnogram to rule out sleep apnea): 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) Pain (Chronic), Polysomnography and Other Medical Treatment Guidelines 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: As the surgical request is not supported, this request is not medically necessary.

Supervised Post-Operative Rehabilitative Therapy (12-sessions, 3 times a week for 4 weeks): Upheld

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

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

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Associated Surgical Service: Surgi Stim Unit (for an initial period of 90-days): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-121.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Associated Surgical Service: Coolcare Cold Therapy Unit: 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 and Leg: Continuous flow cryotherapy.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.