

Case Number:	CM15-0048680		
Date Assigned:	03/20/2015	Date of Injury:	04/07/2011
Decision Date:	05/12/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/16/2015

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

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 45-year-old male who reported an injury on 11/12/2002 due to a fall and altercation. His diagnoses include lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome, bilateral sacroiliac joint sprain/strain, and left knee sprain/strain. His past treatments include physical therapy, home exercise program, activity modifications, and medications. A left knee MRI performed on 11/17/2014 revealed mild chondromalacia of the patella, scarring of the infrapatellar Hoffa's fat pad, and small joint effusion. There was absence of anterior/posterior cruciate ligament tears, meniscal tears, no fracture or contusion. On 02/17/2015, the injured worker complained of low back pain and left knee pain rated 5/10 with medication, 8/10 without medications. The injured worker indicated that the left knee pain was severe. Physical examination of the left knee revealed range of motion with flexion at 125 degrees and extension at 0 degrees. The injured worker had a positive patellar compression and positive McMurray's on the left. The injured worker had normal left knee muscle strength, reflexes, and sensation on the left. The treatment plan indicated the injured worker might be a candidate for a lumbar epidural steroid injection and/or facet injections. Follow-up was recommended for the injured worker's left knee symptomology. A request was received for left knee arthroscopic evaluation and arthroscopic plica resection, chondroplasty, debridement and synovectomy with open exploration debridement patellar tendon with distal pole of the patella, pre-operative clearance, post-operative physical therapy for the left knee three times a week for 4 weeks, continuous flow

cryotherapy, associated surgical service- Surgi-Stim unit #90 days, and associated surgical service- Coolcare cold therapy unit #90 days. A rationale was not provided. A Request for Authorization form was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left knee arthroscopic evaluation and arthroscopic plica resection, chondroplasty, debridement and synovectomy with open exploration debridement patellar tendon with distal pole of the patella: 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), knee chapter.

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: According to the Official Disability Guidelines, chondroplasty is indicated for patients who have had conservative care to include medications or physical therapy in addition to subjective findings of joint pain and swelling, objective findings of effusion, crepitus, limited range of motion, and chondral defect on MRI. The injured worker had left knee pain complaints with decreased flexion on the left. The injured worker also had a positive patellar and McMurray's test. However, the MRI submitted for review failed to indicate significant chondral defect. In addition, there was lack of documentation indicating the injured worker had a full patellar tendon tear or rupture. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary or appropriate at this time.

Pre-operative clearance: Upheld

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

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.

Post-operative physical therapy for the left knee three times a week for 4 weeks: 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), knee chapter.

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 services: Continuous flow cryotherapy: Upheld

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

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- Surgi-Stim unit #90 days: Upheld

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

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- Coolcare cold therapy unit #90 days: Upheld

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

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.