

Case Number:	CM15-0086671		
Date Assigned:	05/08/2015	Date of Injury:	09/27/2013
Decision Date:	06/30/2015	UR Denial Date:	04/20/2015
Priority:	Standard	Application Received:	05/05/2015

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 51-year-old male who sustained an industrial injury on 9/27/13. Injury occurred when twine was wrapped around his right ankle and he felt a sharp pull on the knee. Past surgical history was positive for right knee medial meniscectomy in January 2014. The 6/26/14 bilateral knee x-rays demonstrated medial joint space narrowing. The 9/16/14 right knee MRI impression documented free edge tear of the body of the medial meniscus, grade 1 medial collateral ligament sprain, and mild osteoarthritis. There were subcutaneous varicosities suggesting an incompetent greater saphenous system. The 3/5/15 treating physician report cited severe right anterior and medial knee pain and popping, increased since the last visit. He reported he was not able to walk very far without extreme pain. He was unable to kneel, bend, walk up stairs, or sit or stand for prolonged periods with increased pain. He reported his knee felt unstable when he walked, and felt like it was shifting. He had difficulty sleeping. There was intermittent swelling. Conservative treatment had included physical therapy, corticosteroid injection, viscosupplementation, ice, anti-inflammatory medication, pain medication, activity modification, and bracing. Right knee exam documented no effusion or swelling, no bone or joint malalignment, range of motion 0-100 degrees, no pain with range of motion, marked tenderness over the medial joint line, stable joint that tracked well with range of motion, positive patellar grind, positive medial McMurray's, and normal strength. The diagnosis was right knee medial meniscus tear, status post right knee medial meniscectomy, knee osteoarthritis, and iliotibial band syndrome. The 4/8/15 treating physician report requested authorization for right knee arthroscopy, post-op physical therapy 3x4, crutches, and Game ready cold therapy and compression unit, 28 day rental. The 4/10/15 utilization review non-certified the right knee arthroscopy and associated surgical request as there were no mechanical symptoms and results of knee arthroscopy in an arthritic knee were poor.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right knee arthroscopy: Overturned

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 & Leg.

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: 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. Guideline criteria have been met. This injured worker presents with severe right knee pain with mechanical signs of popping, intermittent swelling, and a feeling of giving way. Clinical exam findings are consistent with imaging evidence of a medial meniscus tear. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Post-op physical therapy 3xwk x 4 wks, Right knee: Overturned

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

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

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

Associated surgical service: Crutches of the right knee: Overturned

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 & Leg.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338. 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.

Associated surgical service: Game ready cold therapy and compression unit, 28 day rental, right knee: 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 & Leg.

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: Cold compression therapy; Game Ready accelerated recovery system; Continuous flow cryotherapy.

Decision rationale: The California MTUS is silent regarding cold compression units. The Official Disability Guidelines generally recommend continuous flow cryotherapy for up to 7 days as an option for patients undergoing knee arthroscopy. Guidelines state that there are no published high quality studies on the Game Ready device or any other combined cold and compression system to support the increased efficacy over cryotherapy alone. There is no compelling reason to support the medical necessity of this request for a non-complex knee procedure in the absence of guideline support for combined cold and compression units and for a duration beyond guideline-recommended cryotherapy. Therefore, this request is not medically necessary.