

<b>Case Number:</b>	CM15-0235741		
<b>Date Assigned:</b>	12/11/2015	<b>Date of Injury:</b>	02/20/2013
<b>Decision Date:</b>	01/21/2016	<b>UR Denial Date:</b>	11/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2015

### 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 44 year old female, who sustained an industrial injury on 2-20-2013. She reported left foot pain. The injured worker was diagnosed as having knee strain, sprain, left hip strain, sprain, left ankle strain, sprain, lumbar spine strain, sprain and left trochanteric bursitis. Treatment to date has included diagnostic testing, activity modification, chiropractic care, injections, physical therapy, and acupuncture. The progress note dated 9-15-2015, the IW complain of continues to experience pain in her left knee, leg, thigh, up to her hip and lower back. On exam, Minor's sigh was present with a moderate limping gait. Lumbar and left tensor fasciae latae (TFL) pain and spasms were noted. Lumbar range of motion was reduced slightly and McMurray's was positive for pain and clicking. The plan is to be seen by an orthopedist. The orthopedic consult progress note dated 9-16-2015, the IW complains of constant sharp, throbbing, burning pain in the right knee. She rates her pain at rest a 7-8 out of 10 with 10 being the worst and with activity a 9. The pain is increased with walking, standing, running, kneeling, squatting, bending, stairs, sitting, lying, pulling and pushing. The pain is alleviated with medication, rest, sitting and lying down. She also complains of weakness and swelling at the ankle. On exam, there is 1+ effusion of the left knee. She has tenderness of the prepatellar bursa and locking of the left knee. She has decreased range of motion. McMurray's test is positive for pain, the spring test is positive. The plan is for surgery. The UR decision, dated 11-5-2015 denied knee arthroscopy, chondroplasty and removal of loose body, surgical assistant, postoperative cold compression unit and postoperative physical therapy, for 12 visits. The request for authorization, dated 11-10-2015 is for denied knee arthroscopy, chondroplasty and

removal of loose body, surgical assistant, postoperative cold compression unit and postoperative physical therapy, for 12 visits.

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

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

#### **Left knee arthroscopy, chondroplasty and removal of loose body: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 13th Edition (web), 2015, Knee & Leg, Chondroplasty and Loose Body removal surgery - Indications for Surgery.

**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 chondroplasty. According to the ODG Knee and Leg regarding chondroplasty, criteria include ALL of the following; conservative care, subjective clinical findings of joint pain and swelling plus objective clinical findings of effusion or crepitus plus limited range of motion plus chondral defect on MRI. In this case the MRI does not demonstrate a clear chondral defect on MRI nor does the exam note demonstrate objective findings consistent with a symptomatic chondral lesion. Therefore the request is not medically necessary.

#### **Surgical Assistant: 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 Cold Compression Unit (7-day rental): 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 12-visits, 2 times a week for 6 weeks: 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.