

Case Number:	CM14-0099949		
Date Assigned:	09/16/2014	Date of Injury:	07/27/2012
Decision Date:	10/15/2014	UR Denial Date:	06/16/2014
Priority:	Standard	Application Received:	06/30/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 53-year-old male electrician who sustained an industrial injury on 7/27/12. Injury occurred when he was squatting for a prolonged period of time working behind a transformer. His right knee popped with pain when he stood up. The injured worker underwent right knee arthroscopic partial medial meniscectomy, chondroplasty, microfracture medial femoral condyle, and partial synovectomy on 12/5/12 with 20 sessions of post-op physical therapy and a home exercise program. Persistent knee pain was reported following recovery from surgery that precluded return to his regular job. The 5/19/14 right knee x-rays documented moderate medial compartment osteoarthritis and suprapatellar joint effusion. The lateral and patellofemoral compartment joint spaces were preserved. The 5/19/14 right knee magnetic resonance arthrogram impression documented a flat tear in the medial meniscus anterior horn, body and posterior horn with findings consistent with an acute tear. There was displaced meniscal tissue along the posterior medial tibial spine. There was a proud osteophyte in the lateral aspect of the medial femoral condyle with mild overlying chondral thinning that is most consistent with chronic sequelae of an osteochondral defect that has healed. The 5/27/14 treating physician report cited continued complaints of anterior and anteromedial pain with ambulation, squatting, stooping, and ascending/descending stairs. Physical exam documented medial joint line tenderness and mild retropatellar tenderness. The treatment plan requested arthroscopic evaluation of the right knee, partial medial meniscectomy, and possible chondroplasty. The treating physician stated that the worker had locking symptoms, swelling, pain, and functional impairment which met the Official Disability Guidelines for surgery. The 6/16/14 utilization review denied the right knee surgery and associated requests as there was no evidence of mechanical symptoms or indication that appropriate conservative treatment had been attempted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right knee arthroscopy evaluation and a partial medial meniscectomy and possible chondroplasty: Overturned

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 Indications for Surgery Meniscectomy/Chondroplasty

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345, 347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Meniscectomy, Chondroplasty

Decision rationale: The Chronic Pain Medical Treatment 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 magnetic resonance imaging scan. 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 magnetic resonance imaging scan. Guideline criteria have been met. Persistent right knee pain is documented with current report of locking and swelling. There has been reasonable conservative treatment, including activity modification and home exercise, and these have not provided sustained benefit. Imaging documented an acute medial meniscus tear and articular thinning. The injured worker has not been able to return to work due to functional limitations. Therefore, this request is medically necessary. The treating physician has documented mechanical symptoms consistent with guidelines and guideline-recommended conservative treatment is noted.

Pre-op medical clearance: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA 2007 Guidelines (<http://circ.ahajournala.org/cgi/content/full/116/17/e418>)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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: The Chronic Pain Medical Treatment Guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all workers undergoing diagnostic or therapeutic procedures. Guideline criteria have been met based on the injured worker's age, magnitude of surgical procedure, recumbent position, fluid exchange and the risks of undergoing anesthesia. Therefore, this request is medically necessary. Surgery has been found medically necessary.

Cold Therapy Purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Knee; Am J Sports Med. 1996 Mar-Apr; 24 (2): 193-5; AJSM, 2004, 32 pages 251-261

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: The Chronic Pain Medical Treatment Guidelines are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery for up to 7 days, including home use. The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and injured worker compliance (but these may be worthwhile benefits) in the outpatient setting. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for purchase which is not consistent with guidelines. Therefore, this request for one cold therapy unit is not medically necessary.

Crutches: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid Services (CMS), 2005

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338-340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Walking aids (canes, crutches, braces, orthoses, & walkers)

Decision rationale: The Chronic Pain Medical Treatment Guidelines support the use of crutches for partial weight bearing for injured workers 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. Surgery has been found medically necessary.

Post-op Physical Therapy times twelve (12): Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24-25.

Decision rationale: The California Post-Surgical Treatment Guidelines for meniscectomy and chondroplasty 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 is medically necessary. Surgery has been found medically necessary.