

Case Number:	CM14-0215155		
Date Assigned:	01/02/2015	Date of Injury:	06/05/2012
Decision Date:	02/28/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	12/23/2014

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. 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: Florida

Certification(s)/Specialty: Family Practice

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 patient is a 55-year-old male with a date of injury of 6/5/2012. The mechanism of injury described is cumulative trauma. The patient has right knee pain and left shoulder pain. A 11/28/2012 ultrasound report of the right knee states that a large right complex medial meniscus tear of the posterior horn was present. This patient has a Pacemaker and so an MRI could not have been performed. It should be noted that a lot of the progress notes are hand written and illegible. Prior treatment has included physical therapy and accupunture therapy, activity modification, and medications. A utilization review physician did not certify multiple requests, including a request for right knee partial medial menisectomy, chondroplasty, and debridement, postoperative physical therapy, home CPM Device, electrical stimulation unit for 90 days, and cool care cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right knee partial medial menisectomy, chondroplasty and debridement to include pre-op clearance.: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Meniscus Tears Page(s): 344.

Decision rationale: MTUS guidelines state regarding Meniscus tears, "Arthroscopic partial meniscectomy usually has a high success rate for cases in which there is clear evidence of a meniscus tear symptoms other than simply pain (locking, popping, giving way, recurrent effusion); clear signs of a bucket-handle tear on examination (tenderness over the suspected tear but not over the entire joint line, and perhaps lack of full passive flexion); and consistent findings on MRI. However, patients suspected of having meniscal tears, but without progressive or severe activity limitation, can be encouraged to live with symptoms to retain the protective effect of the meniscus. If symptoms are lessening, conservative methods can maximize healing. In patients younger than 35, arthroscopic meniscal repair can preserve meniscal function, although the recovery time is longer compared to partial meniscectomy. Arthroscopy and meniscus surgery may not be equally beneficial for those patients who are exhibiting signs of degenerative changes." Regarding this patient's case, an US was performed (since he has a Pacemaker and could not have an MRI performed,) which showed a LARGE meniscus tear. This patient has been examined by 2 different Orthopedic surgeons and surgery has been recommended on two separate occasions. The physical exam findings noted on the 11/2014 Orthopedic evaluation support surgical treatment. Positive medial joint line tenderness, effusion, and abnormal alignment are documented in the right knee. Surgery is considered medically necessary and appropriate in this case.

Associated surgical service: post-op physical therapy 3x4 (confirmed with [REDACTED] at [REDACTED] office): Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 24.

Decision rationale: MTUS guidelines state regarding physical therapy status post Meniscectomy, "Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee; Dislocation of patella: Postsurgical treatment: (Meniscectomy): 12 visits over 12 weeks *Postsurgical physical medicine treatment period: 6 months." 3x4 visits have been requested and this is the recommended number of treatments according to MTUS Guidelines. Likewise, this request for treatment is considered medically necessary

Associated surgical service: Electric stim unit for 90 days.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-117.

Decision rationale: California MTUS guidelines recommend the following regarding criteria for TENS unit use: 1. Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. 2. There is evidence that other appropriate pain modalities have been tried (including medication) and failed- A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial³. Other ongoing pain treatment should also be documented during the trial period including medication usage⁴. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted⁵. A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. This patient's case does not meet the recommended criteria since a 3 month period is being requested instead of a 1 month trial period of use. Also, no treatment plan (that includes short and long term goals) was submitted. There is also no documentation that other treatment modalities have been tried and failed. Likewise, this request for a TENS unit is not medically necessary.

Associated surgical service: Surgi-stim unit cool care cold therapy unit.: 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)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee Chapter

Decision rationale: MTUS guidelines are silent on surgi-tim unit cool care cold therapy unit use postoperatively. Therefore, the ODG guidelines were referenced. These guidelines support their use in the immediate postoperative period. ODG states that "in the postoperative setting, continuous flow cryotherapy units have been proved to decrease pain, inflammation, swelling, and narcotic usage." Likewise, this request for a surgi-stim unit cool care cold therapy unit is considered medically necessary.

Associated surgical service: Home CPM device 14 days: 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)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee Chapter

Decision rationale: A home Continuous Passive motion device for an initial 14 day postoperatively has been requested by the patient's Orthopedic surgeon. The purpose of this device is to encourage early restoration of range of motion. MTUS guidelines do not address this request. ODG does state criteria for this device. "Postoperative use may be considered medically necessary for up to 21 consecutive days, for the following surgical procedures: Total knee

arthroplasty, anterior cruciate ligament reconstruction, open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint." This patient's case does not meet the recommended guideline criteria, and use of this device is not considered medically necessary in this case.