

<b>Case Number:</b>	CM15-0007825		
<b>Date Assigned:</b>	01/26/2015	<b>Date of Injury:</b>	09/13/2014
<b>Decision Date:</b>	03/18/2015	<b>UR Denial Date:</b>	12/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/14/2015

### 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: New York, New Hampshire, Washington  
 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 54 year old male, who sustained an industrial injury on 9/13/14. He has reported injury to cervical spine, lumbar spine, left shoulder, left knee, left leg and left ankle. The diagnoses have included severe impingement syndrome left shoulder, possible rotator cuff injury and labral injury left shoulder, left knee lateral meniscus tear, painful retained hardware left fibula, contusion distal left tibia, cervical degenerative disc disease, cervical strain, possible rotator cuff injury and cervical strain. Treatment to date has included physical therapy and medications. X-rays dated 12/15/14 noted advanced degenerative disc disease of L3-4, L4-5 and L5-S, left shoulder type II acromion, AC joint arthropathy, left knee previous rodding to left tibia from prior injury and lateral compartment narrowing of left knee, left tibial with screws in the distal portion of rod and cervical spine degenerative disc disease of C3-4, C4-5 and C5-6. Subjective symptoms were not noted. The exam noted on the PR2 dated 12/15/14 revealed cervical spine restricted with pain and tenderness to palpation at paracervical area, lumbar spine range of motion limited with pain, tenderness to palpation of paralumbar region, left shoulder severe pain with abduction and left knee swelling and tenderness to palpation medial aspect distal 1/3 tibia. On 12/29/14 Utilization Review non-certified left knee arthroscopy, partial meniscectomy and removal of 2 distal interspace screws of the left tibia, noting the lack of documentation of symptoms. Post op physical therapy for the left knee and post-operative use of cold therapy unit for the left knee was non-certified due to non-certification of surgery. On 12/29/14, Utilization Review non-certified 12 sessions of physical therapy for left shoulder, noting lack of documentation of objective functional improvement following previous physical

therapy and insufficient information. The MTUS and ODG were cited. On 1/6/15, the injured worker submitted an application for IMR for review of left knee arthroscopy, partial meniscectomy and removal of 2 distal interspace screws of the left tibia, initial post-op physical therapy for left knee 3 times per week for 4 weeks post left knee arthroscopy, post-operative use of cold therapy unit for the left knee and additional physical therapy for the left shoulder 3 times per week for 4 weeks.

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

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

**Left knee arthroscopy, partial lateral meniscectomy, removal of 2 distal interspace screws of the left tibia:** 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 & Leg (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-350.

**Decision rationale:** 54 y.o. male with neck, back, shoulder, and knee pain. MTUS criteria for knee surgery not met. There is no documentation of physical exam findings that clearly correlate with imaging studies. There is no complete meniscal tear on mri. There is no documentation that the screws are symptomatic. Surgery is not needed.

**12 initial post operative physical therapy for the left knee, 3x4:** Upheld

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

**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.

**7 post operative use of cold therapy unit for the left knee, 7 day rental:** 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 & Leg (Acute & Chronic), Continuous flow cryotherapy

**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.

**12 additional physical therapy sessions for the left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212.

**Decision rationale:** The medical records do not document significant improvement of symptoms with previous PT. Additional shoulder PT not needed. MTUS guidelines for more shoulder PT not met.

**12 additional physical therapy for the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 270-300.

**Decision rationale:** The medical records do not document significant improvement of symptoms with previous PT. Additional low back PT not needed. MTUS guidelines for more low back PT not met. Improvement not shown with previous PT.