

<b>Case Number:</b>	CM15-0010937		
<b>Date Assigned:</b>	01/28/2015	<b>Date of Injury:</b>	11/16/2011
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	12/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/16/2015

### 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 59-year-old male, who sustained a cumulative trauma industrial injury to the right knee from 01/1989-11/16/11. Past medical history was positive for diabetes mellitus, hyperlipidemia, enlarged/fatty liver, and history of renal cysts in both kidneys. The 9/13/13 right knee MRI impression documented an oblique tear at the posterior horn of the medial meniscus, mild knee joint effusion, mild tricompartmental osteoarthritis, and moderate chondromalacia of the medial compartment. Conservative treatment for the right knee has included physical therapy, bracing, home exercise program, medications, and activity modification. The 9/22/14 treating physician report documented on-going right knee symptoms with giving way. Orthopedic consult was pending. The 10/10/14 orthopedic consult report cited on-going right knee pain despite time and aggressive conservative management. MRI findings showed an oblique tear of the right medial meniscus at the posterior horn. Right knee exam documented range of motion 0-120 degrees, medial joint line tenderness, effusion, and positive McMurray's. Diagnostic right partial medial meniscectomy, chondroplasty and debridement were recommended. The 12/9/14 treating physician report cited right knee pain and weakness with difficulty in standing, walking, kneeling, and stair climbing. Continued home exercise program was noted. Physical exam documented range of motion 0-115 degrees with patellofemoral crepitus, medial joint line tenderness, positive McMurray's, and 4/5 flexion/extension weakness. The treating physician reported the injured worker is an excellent candidate for right knee surgery per the surgery consultation report of 10/10/14. The patient was unable to work. A 12/12/14 treating physician appeal letter indicated the patient had failed to improve with prior

physical therapy in 2013. The patient had constant right knee pain with persistent popping, catching, mistrust, and giving way, with substantial functional difficulties. He opined that further conservative treatment would not improve his mechanical complaints. Utilization Review determination on 12/16/14 non-certified the request for 1 Arthroscopic Right Knee Partial Medial Meniscectomy, Chondroplasty, and Debridement, 1 Pre-Operative Medical Clearance, 2 Supervised Postoperative Rehabilitative Therapy Sessions, 14 days use of Home Continuous Passive Motion (CPM), 90 days use of Surgi-stim Unit, and 1 Cool Care Cold Therapy Unit citing American College of Occupational and Environmental Medicine, Chronic Pain Medical Treatment Guidelines, and Official Disability Guidelines. Non-certification was based on an absence of focused physical therapy or injection to the right knee, and inconsistent documentation of mechanical symptoms.

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

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

**Arthroscopic right knee partial medial meniscectomy, chondroplasty and debridement:**  
Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Knee and Leg: Meniscectomy; Chondroplasty

**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 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 MRI. Guideline criteria have been met. This patient presents with on-going function-limiting right knee pain with associated complaints of giving way, popping, and catching. Clinical exam findings are consistent with imaging evidence of a medial meniscus tear and medial compartment chondromalacia. Reasonable conservative treatment, including on-going home exercise program, activity modification, and medications, has failed. Therefore, this request is medically necessary.

**1 preoperative medical clearance:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule, 1999 edition, pages 92-93

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guideline criteria have been met. Middle-aged males have known occult increased medical/cardiac risk factors. This injured worker additionally has a history of diabetes mellitus and liver/kidney issues. Given these clinical indications, this request is medically necessary.

**12 supervised postoperative rehabilitative therapy sessions:** 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 MTUS 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.

**14 days use of home continuous passive motion:** 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:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee and Leg: Continuous passive motion (CPM)

**Decision rationale:** The California MTUS does not provide recommendations for this device following knee arthroscopy. The Official Disability Guidelines recommend the use of continuous passive motion (CPM) devices in the hospital for up to 21 days for patients who have undergone

primary or revision total knee arthroplasty. There is no guideline support for the routine or prophylactic use of a CPM unit following knee arthroscopy. There is no compelling reason to support the medical necessity of CPM for this patient in the absence of guideline support. Therefore, this request is not medically necessary.

**90 days use of Surgi-stim unit:** 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:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

**Decision rationale:** The SurgiStim unit provides a combination of interferential current, neuromuscular electrical stimulation (NMES), and galvanic current. The California MTUS guidelines for transcutaneous electrotherapy do not recommend the use of NMES or galvanic stimulation in the treatment of chronic pain. Guidelines suggest that interferential current is not recommended as an isolated intervention. Guidelines support limited use of TENS unit in the post-operative period for 30 days. Guideline criteria have not been met. If one or more of the individual modalities provided by this multi-modality unit is not supported, then the unit as a whole is not supported. There is no compelling reason to support the medical necessity of this unit in the absence of guideline support. There is no indication that standard post-operative pain medication will be inadequate to control pain based on pre-operative pain reduction documented with medication. Therefore, this request is not medically necessary.

**1 cool care cold therapy unit:** 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 (Acute & Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee and Leg: Continuous flow cryotherapy

**Decision rationale:** The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after knee surgery for up to 7 days. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request for one cold therapy unit is not medically necessary.