

Case Number:	CM15-0175176		
Date Assigned:	09/17/2015	Date of Injury:	12/01/2009
Decision Date:	10/19/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	09/08/2015

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, Oregon, 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 48 year old female, who sustained an industrial injury on 12-01-09. Medical record indicated the injured worker is undergoing treatment for left knee chondromalacia and status post open reduction-internal fixation of left patella fracture. Treatment to date has included left knee arthroscopy with debridement, open reduction internal fixation of left patella; oral medications including Norco 10-325mg, Anaprox 550mg and Prilosec 20mg; Supartz injections (which helped to reduce the pain) and activity restrictions. (MRI) magnetic resonance imaging of left knee revealed significant patellofemoral joint disease with chondromalacia and evidence of previous patellar fracture, which is well healed. Currently on 7-20-15 and 8-6-15, the injured worker complains of ongoing left knee pain. Work status is noted to be modified restrictions. Physical exam performed on 7-20-15 and 8-6-15 revealed crepitation with range of motion and tenderness across the patella and at medial joint line without instability. The treatment plan included a request for authorization for left knee arthroscopy and debridement with 12 post-operative physical therapy visits and a polar care unit. On 8-11-15, utilization review non-certified a request for left knee arthroscopy and debridement noting the surgical procedure is not medically necessary per guidelines and post-operative physical therapy and polar care unit are not necessary as the surgery was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left knee arthroscopy, debridement, chondroplasty: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

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 regarding chondroplasty.

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.

Post-op physical therapy for the left knee 12 sessions: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-op polar care unit: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.