

<b>Case Number:</b>	CM15-0072880		
<b>Date Assigned:</b>	04/23/2015	<b>Date of Injury:</b>	10/15/2014
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	04/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/16/2015

### 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 61-year-old male who sustained an industrial injury on 10/15/14. Injury occurred when he stepped on a board and it tilted, resulting in a hyperextension injury to his left knee. Past medical and surgical history was reported negative. The 2/13/15 left knee weight bearing x-rays demonstrated no significant joint space narrowing in either knee. The left knee appeared to have 2-3 loose bodies in the back of the notch with some patellofemoral spurring without malalignment. There was a spur in the anterior part of the notch that appeared longstanding. The 3/11/15 left knee MR arthrogram impression documented an irregular defect at the meniscal root of the posterior horn of the medial meniscus consistent with a tear. There was a large Baker's cyst and loose bodies within the posterior recess along the inner side of the medial compartment. There were chondromalacic changes of the medial femoral condyle, chondral defect lateral femoral condyle, and chondromalacia patella There were minor degenerative changes within the medial compartment as evidenced by marginal osteophyte bordering a partially subluxed body of the medial meniscus. The 3/25/15 orthopedic report cited continued moderate to severe medial and lateral left knee pain that restricted normal activity. Left knee exam documented small effusion, medial and lateral joint line tenderness, normal strength, range of motion 0-90 degrees with pain, mild swelling, and positive McMurray's, Bounce, and Apley's tests. There was no crepitus or instability. Imagining and radiographs were reviewed. Findings were positive for horizontal cleavage tear of the medial meniscus, and possible lateral meniscus tear. Authorization was requested for left knee arthroscopic repair internal derangement, DonJoy Iceman and pad, 12 physical therapy visits, pre-op chest x-ray, and pre-op EKG. The 4/7/15 utilization review non-certified the left knee arthroscopy and repair of internal derangement and associate surgical requests as there was no evidence of conservative treatment failure and there was evidence of degenerative disease. The 4/16/15 orthopedic surgeon appeal letter stated that the injured worker had conservative management, including

over-the-counter analgesics, activity modification, home exercise, knee sleeve, modified work, and Voltaren as dispensed by his primary treating physician. The injured worker was referred for orthopedic consult following failure of conservative management. The injured worker had left knee pain with swelling, popping and locking. He had positive McMurray's and Apley's tests, effusion, and medial and lateral joint line tenderness. The obvious internal derangement of the knee required surgical treatment despite some underlying and pre-existing degenerative changes. Physical therapy and injections were not appropriate based on the known medial meniscus root tear.

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

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

#### **Left Knee Arthroscopy, Repair Internal Derangement: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

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

**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. Guideline criteria have been met. This injured worker presents with persistent left knee pain with swelling, popping, and locking. Clinical exam findings are consistent with imaging evidence of meniscal tear. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

#### **Associates Surgical Services: Don Joy Iceman & Pad: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Continuous-flow cryotherapy.

**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 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, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. 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 is not medically necessary.

#### **Associates Surgical Services: 12 Physical Therapy: Overturned**

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

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

**Decision rationale:** The California Post-Surgical Treatment Guidelines for meniscectomy 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 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 for is medically necessary.

#### **Pre Operative Chest X-Ray: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Chest X-ray.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACR Appropriateness Criteria® routine admission and preoperative chest radiography. Reston (VA): American College of Radiology (ACR); 2011. 6 p.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines state that routine pre-operative chest radiographs are not recommended except when acute cardiopulmonary disease is suspected on the basis of history and physical examination. Middle-aged males have known occult increased medical/cardiac risk factors to support the medical necessity of pre-procedure chest x-ray. Guideline criteria have been met based on patient age and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

#### **Pre Operative EKG: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA Clinical Competence, Electrocardiography and Ambulatory Electrocardiography.

**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 California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines state that an EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. Guideline criteria have been met. Middle-aged males have known occult increased risk factors for cardiovascular disease that support the medical necessity of pre-procedure EKG. Therefore, this request is medically necessary.