

Case Number:	CM15-0097785		
Date Assigned:	05/28/2015	Date of Injury:	05/08/2012
Decision Date:	07/08/2015	UR Denial Date:	05/13/2015
Priority:	Standard	Application Received:	05/20/2015

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 29-year-old female who sustained an industrial injury on 5/8/12, relative to a slip and fall. She underwent left knee arthroscopy with medial meniscectomy and debridement in 2012. The 1/29/15 treating physician report indicated that the injured worker had a corticosteroid injection on 1/20/15 for worsening left knee pain. She reported no improvement with the injection and reported difficulty flexing and extending her knee, and also a feeling of locking when walking. She also reported spasms around the medial knee at night. She was tolerating full duty work. Left knee exam documented range of motion 30-120 degrees with medial pain on pressure with flexion and extension. McMurray's, Lachman's, varus/valgus stress, and anterior and posterior drawer tests were negative. The injured worker was prescribed Ibuprofen and cyclobenzaprine and referred to orthopedics. The 4/3/15 left knee MRI impression documented minimal inner margin tear at the junction of the body and posterior horn of the medial meniscus, and discoid lateral meniscus without evidence for meniscal tear. There was an 8x8 mm grade 2-3 chondral fissuring, delamination at the inner central medial femoral condyle, and 6x6 mm grade 3 chondral fissuring, and delamination at the central paramedian lateral patellar facet. The 5/5/15 orthopedic report cited persistent left medial knee joint line tenderness with difficulty bending or squatting due to pain. Physical exam documented range of motion 0-120 degrees, positive McMurray's, and mild effusion. MRI showed a traumatic osteochondral lesion on the medial femoral condyle and a medial meniscus tear. There was a central chondral lesion of 8x8 mm that would benefit from autograft OATS procedure. Authorization was requested for left knee arthroscopy with medial meniscectomy and medial femoral condyle and

osteochondral transfer, post-op physical therapy 12 sessions, cold therapy unit, and crutches. The 5/13/15 utilization review non-certified the request for left knee arthroscopy with medial meniscectomy, medial femoral condyle and osteochondral transfer and associated surgical requests as there was no evidence of a cortisone injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Knee Arthroscopy with Medial Meniscectomy: Upheld

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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg: Meniscectomy.

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 have not been met. This injured worker presents with an increase in left knee pain and is 3-years status post left knee partial medial meniscectomy. She is tolerating full duty work status. Clinical exam is consistent with meniscal pathology. Imaging documented minimal medial meniscus tear. However, detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including physical therapy and/or exercise, and failure has not been submitted. Therefore, this request is not medically necessary at this time.

Medial Femoral Condyle and Osteochondral Transfer: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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: Osteochondral autograft transplant system (OATS).

Decision rationale: The California MTUS guidelines state that cartilage grafts and/or transplantations for osteochondral defects may be effective in patients less than 40 years old with active lifestyles, exhibiting a singular traumatically caused grade III or IV femoral condyle deficit that is less than 20 mm. Grafts and transplants are not recommended for individuals with obesity, inflammatory conditions or osteoarthritis, other chondral defects, associated ligamentous or meniscus pathology, or who are greater than 55 years of age. The Official Disability Guidelines criteria for the osteochondral autograft transplant system (OATS) include medication or physical therapy, and joint pain and swelling. Objective clinical findings include failure of previous subchondral drilling or microfracture, intact and fully functional menisci and ligaments, normal knee alignment, normal joint space, and body mass index less than 35. Imaging evidence of a chondral defect on the weight-bearing portion of the medial or lateral femoral condyle is required. Guideline criteria have not been met. This injured worker presents with left knee pain status post left knee partial medial meniscectomy. Clinical exam finding was reported consistent with medial meniscus tear. There is imaging evidence of minimal meniscal tear, and two osteochondral lesions. There was a grade 2-3 chondral lesion measuring 8x8 at the medial femoral condyle, and grade 3 chondral lesion measuring 6x6 at the lateral patellar facet. There is no evidence of previous subchondral drilling or microfracture. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

Post-Operative 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated Surgical Service: Cold Therapy Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated Surgical Service: Crutches: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.