

Case Number:	CM14-0144705		
Date Assigned:	09/12/2014	Date of Injury:	10/14/2009
Decision Date:	10/06/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/08/2014

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. The expert reviewer is Board Certified in Orthopaedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 42 year-old female sustained an industrial injury on 10/14/09 relative to a trip and fall onto her right knee. Injury was reported to the low back and knee. The patient underwent right knee arthroscopy surgery on 6/24/10 and right knee arthroscopic partial synovectomy on 10/5/12. Records indicated the patient had persistent knee pain and intermittent swelling. The 7/23/14 pain management report cited continued low back pain radiating to the right lower extremity. MRI findings noted multilevel lumbar disc protrusions with mild stenosis. There was EMG evidence of right L4/5 radiculopathy. The patient had failed conservative treatment for the lumbar spine and surgical consult was requested. The patient was working part time. The 8/4/14 right knee MRI impression documented a small free margin tear in the mid-body of the lateral meniscus. Findings were compatible with mild pes anserine peritendinitis, and early patellofemoral chondrosis which may be associated with patellofemoral impingement. The 8/12/14 treating physician report documented tenderness over the lateral joint line and slightly medially, mild effusion, good motion, and no instability. MRI showed a free margin tear in the mid-body of the lateral meniscus and normal medial meniscus. The 8/19/14 utilization review denied the right knee surgery and associated requests based on an absence of documented mechanical symptoms or clinical exam findings to support the medical necessity of the requested surgery. Conservative treatment had included activity modification, medication, physical therapy, corticosteroid injection and home exercise.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 pair of crutches: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines); Walking Aids

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338-340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Walking aids (canes, crutches, braces, orthoses, & walkers)

Decision rationale: The California MTUS guidelines support the use of crutches for partial weight bearing for patients with knee complaints. The Official Disability Guidelines state that disability, pain, and age-related impairments determine the need for a walking aid. Assistive devices can reduce pain and allow for functional mobility. Post-operative crutch use would be consistent with guidelines. Therefore, this request is medically necessary.

1 purchase of Cryotherapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines); 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 surgery for up to 7 days, including home use. The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting. While there is guideline support for up to 7 days use, the purchase of a cold therapy unit is not consistent with guidelines. Therefore, this request is not medically necessary.

1 right knee arthroscopy for a lateral meniscus tear: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines); Arthroscopic medial repair

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345, 347.

Decision rationale: The California MTUS guidelines state that arthroscopic partial meniscectomy may be highly successful in cases with clear evidence of a meniscus tear,

symptoms other than pain, clear signs of a bucket handle tear on exam, and consistent findings on MRI. The Official Disability Guidelines provide specific criteria for meniscectomy or meniscus repair that 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. Subjective, objective, and imaging exam findings are consistent with meniscal pathology and meet guideline criteria. Records document persistent knee pain and swelling. Exam findings include lateral joint line tenderness and effusion. Imaging documented a lateral meniscus tear. Medications and activity alterations have been tried and failed. Therefore, this request is medically necessary.

24 postoperative physical therapy visits: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

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. 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 request exceeds the recommendations for the general course of treatment. There is no compelling reason presented to support an initial post-op physical therapy request beyond 12 visits. Therefore, this request is not medically necessary.