

<b>Case Number:</b>	CM13-0058874		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	10/28/2008
<b>Decision Date:</b>	11/14/2014	<b>UR Denial Date:</b>	11/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/27/2013

### 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 Orthopedic 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 is a 42-year-old gentleman who sustained an injury to his right knee on 10/28/08. The clinical records provided for review included a report of an MRI dated 11/23/12 that identified soft tissue scarring of the distal patellar tendon related to the ongoing stress changes of Osgood-Schlatter's Disease. There was also evidence of a prior healed posterior cruciate ligament sprain but no evidence of definitive meniscal tearing or anterior cruciate ligament injury. The progress report dated 07/01/13 described ongoing complaints of knee pain with crepitation, tenderness over the medial femoral condyle, a positive Lachman's, and valgus laxity. The progress report documented that the claimant had failed conservative care of viscosupplementation injections, medication management, physical therapy, and immobilization and recommended "right knee arthroscopy, debridement, chondroplasty, and ligamentous reconstruction." Documentation of telephone correspondence with the treating provider's physician's assistant on 11/08/13 indicated that the claimant had previously undergone lateral retinacular release with arthroscopic chondroplasty in 2009; there was no documentation of further imaging studies. The documentation of telephone correspondence stated that the need for ligamentous reconstruction of the anterior cruciate ligament was based on the claimant's physical examination findings at the last clinical assessment. No other clinical records were available for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pre-op medical clearance for the right knee:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA 2007 Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004); Chapter 7, Independent Medical Examinations and Consultations, page 127.

**Decision rationale:** Based on California ACOEM Guidelines, the request for preoperative medical clearance for the right knee cannot be recommended as medically necessary. The medical records provided for review do not contain any documentation that the claimant has any significant past medical history or underlying comorbidity that would necessitate preoperative assessment prior to an arthroscopic knee procedure. The medical records indicate the claimant is a healthy 45-year-old gentleman and therefore, would not require preoperative medical clearance before an arthroscopic knee procedure.