

Case Number:	CM13-0065863		
Date Assigned:	01/03/2014	Date of Injury:	11/12/2011
Decision Date:	03/27/2014	UR Denial Date:	11/22/2013
Priority:	Standard	Application Received:	12/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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:

The Patient is a 73-year-old male Date of injury 11/12/11. Exam notes from 9/11/13 demonstrate patent complaints of right leg pain with numbness and tingling. Exam shows tenderness to the left knee, decreased (ROM) range of motion, positive McMurray's. Surgery on 4/20/12-left shoulder arthroscopy with rotator cuff repair and subacromial decompression. Exam notes from 1/1/13 demonstrate chief complaint of left knee pain. Exam shows tenderness to palpation, an effusion, positive cepitus, positive McMurray's and wasting. 7/18/13 exam notes demonstrate left shoulder pain, bilateral knee pain and ongoing knee buckling. Exam notes from 8/20/13 demonstrates ongoing left shoulder and bilateral knee pain. Exam revealed C/S with tenderness, decreased ROM, Chiro x 19 has been completed. X-ray from 12/26/13 demonstrates degenerative arthritis more prominent in tibiofemoral joint. There is partial loss of joint space involving medial compartment, suprapatellar effusion, chronic quadriceps muscle tendinitis. Request for left knee arthroscopic meniscectomy

IMR ISSUES, DECISIONS AND RATIONALES

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

for Left Knee Arthroscopic 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): 344-345.

Decision rationale: Knee Complaints Chapter (ACOEM Practice Guidelines, states regarding meniscus tears, "Arthroscopic partial meniscectomy usually has a high success rate for cases in which there is clear evidence of a meniscus tear--symptoms other than simply pain (locking, popping, giving way, recurrent effusion); clear signs of a bucket handle tear on examination (tenderness over the suspected tear but not over the entire joint line, and perhaps lack of full passive flexion); and consistent findings on MRI. However, patients suspected of having meniscal tears, but without progressive or severe activity limitation, can be encouraged to live with symptoms to retain the protective effect of the meniscus. If symptoms are lessening, conservative methods can maximize healing. In patients younger than 35, arthroscopic meniscal repair can preserve meniscal function, although the recovery time is longer compared to partial meniscectomy. Arthroscopy and meniscus surgery may not be equally beneficial for those patients who are exhibiting signs of degenerative changes." There is evidence in the records of osteoarthritis of the knee and no MRI demonstrating meniscus tear. Therefore the determination is not medically necessary