

<b>Case Number:</b>	CM14-0013391		
<b>Date Assigned:</b>	02/26/2014	<b>Date of Injury:</b>	08/31/2013
<b>Decision Date:</b>	06/26/2014	<b>UR Denial Date:</b>	01/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2014

### 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 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:

The patient sustained an industrial injury on 8/31/13. Injury occurred when his right foot stepped through a hole that was covered by Astroturf in a garden shed, and he twisted and hyperextended his right knee. The 9/13/13 right knee MRI documented intense marrow edema affecting the lateral femoral condyle with curvilinear subchondral sclerosis and articular surface depression over 2.2 cm area consistent with sequela of previous insufficiency fracture versus impaction injury, spontaneous osteonecrosis of the knee would be a secondary consideration. There was amorphous appearance of the proximal anterior cruciate ligament (ACL) fibers with adjacent marrow edema affecting the tibial spine distally which may be reactive or contusional in nature, sequela of mucoid degeneration versus partial thickness tear, considered moderate grade involvement. The bulk of the anterior fibers remain taut and intact. There was subtle degenerative fraying of the lateral meniscus, as well as degenerative signal in the medial meniscus. There was low grade chondromalacia with joint effusion. The patient underwent right knee cortisone injection on 9/26/13 with some symptom relief for 3 days. The 11/19/13 progress report cited constant right medial knee pain with locking/catching, stiffness, instability, and limited range of motion, and right lower leg and foot pain. Right knee exam findings documented ambulation with a cane, medial joint and lateral joint line tenderness, mild effusion, positive valgus stress, Lysholm 20, IKDC 16.1, and range of motion was 0-100 degrees. The diagnosis was medial meniscus tear and anterior cruciate ligament insufficiency. There had been no change in symptoms. The treatment plan recommended continued non-steroidal anti-inflammatory, light duty, and right arthroscopic ACL reconstruction, synovectomy, chondroplasty, and medial and lateral meniscectomy. The 1/10/14 utilization review denied the surgical request based on a lack of hallmark physical findings of ACL deficiency, MRI findings of partial ACL tear with the majority of the ligament taut, not suggestive of true ACL laxity, and

lack of physical therapy. The 1/21/14 progress report indicated that symptoms had worsened despite performing home exercises. He was ambulating with a cane and presented with intermittent medial knee pain, constant at night and in the morning, some instability, a feeling of insecurity, locking/catching, mild swelling, a "splinter feeling", snapping, grinding, and weakness. Right knee exam findings documented absent atrophy, medial joint line tenderness, moderate medial McMurray's, right knee range of motion 0-100 degrees limited by pain, and normal lower extremity strength. The treatment plan recommended continued anti-inflammatory, ice, home exercise, and operative treatment including right knee arthroscopic ACL reconstruction, medial and lateral meniscectomy, synovectomy, and debridement. The patient remained on light duty.

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

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

#### **KNEE ARTHROSCOPY/SURGERY: 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. Anterior cruciate ligament reconstruction generally is warranted only for patients who have significant symptoms of instability caused by anterior cruciate ligament incompetence. Arthroscopic partial meniscectomy usually has a high success rate for cases in which there is clear evidence of a meniscus tear. Guideline criteria have been met. This patient presents with worsening symptoms despite reasonable conservative treatment. Symptoms include persistent medial knee pain, constant at night and in the morning, instability, insecurity, locking/catching, mild swelling, snapping, grinding, and weakness. Functional limitations have precluded return to full duty. Exam documented medial joint line tenderness, positive McMurray's, and range of motion limited by pain. MRI findings suggest a moderate grade partial tear of the anterior cruciate ligament and medial meniscal involvement. Therefore, the request for knee arthroscopy/surgery is medically necessary and appropriate.