

<b>Case Number:</b>	CM14-0015606		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	05/27/2001
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	01/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/07/2014

### 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 Pennsylvania. 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 is a 53-year-old with a reported injury date of May 27, 2001. The medical records provided for review document a right knee injury for which a right knee arthroscopy, partial medial meniscectomy, debridement and synovectomy was performed on April 29, 2010. Postoperatively, it is documented that the claimant has had continued knee complaints. The report of an arthrogram of the right knee performed on August 20, 2013 identified undersurface signal change of the posterior horn and body of the medial meniscus consistent with postoperative changes. The lateral meniscus was intact with no tearing demonstrated. There was spurring at the ACL but no tearing and complete cartilage loss over the medial compartment. The progress report of November 6, 2013 identified a large joint effusion for which aspiration was performed. The report documented that the claimant had failed conservative care including aspiration, injection, medication management and previous postoperative treatment. There was discussion regarding viscosupplementation injections. The recommendation was made for revision diagnostic/operative knee arthroscopy with meniscectomy and debridement.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**OUTPATIENT SURGICAL PROCEDURE: RIGHT KNEE REVISION  
DIAGNOSTIC/OPERATIVE ARTHROSCOPIC MENISCECTOMY VS. REPAIR  
POSSIBLE DEBRIDEMENT AND/OR CHONDROPLASTY: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM PRACTICE GUIDELINES 2ND EDITION, 2004, CHAPTER 13-KNEE COMPLAINTS, 343-345

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-45.

**Decision rationale:** Based on the Knee Complaints Chapter of the ACOEM Practice Guidelines, knee arthroscopy with meniscectomy cannot be recommended as medically necessary. The medical records identify that the claimant has imaging including a August 20, 2013, MR arthrogram that reveals full thickness cartilage loss to the medial compartment and no documentation of true meniscal pathology in addition to clinical findings consistent with postoperative changes to both the medial and lateral meniscus. The Knee Complaints Chapter of the ACOEM Practice Guidelines recommend that knee arthroscopy and meniscal surgery in individuals with advanced underlying arthritis yield less than optimal outcomes. The claimant's findings of advanced degenerative arthritis with no indication of mechanical symptoms or imaging findings of acute meniscal pathology would fail to support the surgical process as requested. The request for outpatient surgical procedure: right knee revision diagnostic/operative arthroscopic meniscectomy vs. repair possible debridement and/or chondroplasty is not medically necessary or appropriate.

**ASSISTANT SURGEON:** 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 Other Medical Treatment Guideline or Medical Evidence: Milliman Care Guidelines 18th edition: assistant surgeon Assistant Surgeon Guidelines (Codes 29240 to 29894) CPT<sup>®</sup> 1/2 Y/N Description 29881 N Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed

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

**TWELVE (12) POST-OPERATIVE PHYSICAL THERAPY SESSIONS FOR THE RIGHT KNEE, 2 TIMES A WEEK FOR 6 WEEKS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: POSTSURGICAL TREATMENT GUIDELINES, ,

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

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

**PERI-OPERATIVE ANTIBIOTICS:** 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) Treatment in Worker's Comp, 18th Edition, 2013 Updates: infectious procedure - Cephalexin (Keflex<sup>®</sup> 1/2) Recommended as first-line treatment for cellulitis and other conditions. See Skin & soft tissue infections: cellulitis. For outpatients with non-purulent cellulitis, empirical treatment for infection due to beta-hemolytic streptococci and methicillin-sensitive *S. aureus*, cephalexin 500 mg QID is recommended, as well for

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