

<b>Case Number:</b>	CM14-0159733		
<b>Date Assigned:</b>	10/03/2014	<b>Date of Injury:</b>	07/25/2009
<b>Decision Date:</b>	10/30/2014	<b>UR Denial Date:</b>	09/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2014

### 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 62-year-old male general farm worker/tractor driver sustained an industrial injury on 7/25/09. Injury occurred relative to a slip and fall, landing on his bent left knee. He underwent left knee arthroscopic partial lateral meniscectomy and repair of the quadriceps mechanism on 8/28/09. The 12/4/13 left knee MRI impression documented a large complex multi-planar tear of the lateral meniscus, most severely involving the body and anterior horn. There was mild arthritis and a full thickness cartilage defect over the posterior aspect of the lateral femoral condyle. There were post-operative changes involving the patella and quadriceps tendon with severe quadriceps tendonitis. There was minimal medial meniscus degeneration. The 9/8/14 treating physician report cited worsening anterolateral knee pain and weakness with catching and locking. Pain is reported with prolonged sitting and he was unable to ascend/descend stairs. Left knee exam documented range of motion 0-120 degrees with lateral joint tenderness, exquisite anterolateral knee pain, and a positive lateral McMurray's. There was +2 patellofemoral crepitus with joint effusion, quadriceps atrophy, moderate hamstring weakness, and weakness in flexion and extension. There was no ligamentous instability. The treatment plan recommended left arthroscopic medial meniscectomy with chondroplasty. The 9/24/14 utilization review denied the left knee surgery and associated physical therapy as there was no recent evidence of conservative treatment failure. Records do not evidence any conservative treatment since 2010.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left arthroscopic medial meniscectomy with chondroplasty:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery - Meniscectomy; Knee & Leg (Acute & Chronic), Indications for Surgery - Chondroplasty

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345, 347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Meniscectomy, Chondroplasty

**Decision rationale:** The California MTUS guidelines support arthroscopic partial meniscectomy for cases in which there is clear evidence of a meniscus tear including symptoms other than simply pain (locking, popping, giving way, and/or recurrent effusion), clear objective findings, and consistent findings on imaging. The Official Disability Guidelines (ODG) criteria for meniscectomy 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. The ODG criteria for chondroplasty include evidence of conservative care (medication or physical therapy), plus joint pain and swelling, plus effusion or crepitus or limited range of motion, plus a chondral defect on MRI. Guideline criteria have not been met. Subjective and clinical exam findings are consistent with imaging evidence of meniscal pathology and chondral lesion. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request of Left arthroscopic medial meniscectomy with chondroplasty is not medically necessary and appropriate.

**Twelve (12) physical therapy sessions:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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