

<b>Case Number:</b>	CM14-0166834		
<b>Date Assigned:</b>	10/14/2014	<b>Date of Injury:</b>	12/23/2010
<b>Decision Date:</b>	11/26/2014	<b>UR Denial Date:</b>	09/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2014

### 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:

60-year-old female claimant with an industrial injury dated 12/22/10. Conservative treatments have included physical therapy, and medication to aid with pain relief. MRI of the right knee dated 01/16/14 reveals a medial meniscus large tear involving the posterior horn of the medial meniscus. MRI of the left knee reveals a new tear in the posterior horn of the medial meniscus, also a decreased size of the medial meniscus. Exam note 06/17/14 states the patient returns with bilateral knee pain and shoulder pain. The patient explains an ongoing right shoulder pain. Upon physical exam, the patient had tenderness surrounding the acromioclavicular joint. The patient demonstrated pain in the rotator cuff tests. There was evidence of positive impingement. The patient explains that the pain is radiating to the right ear and right jaw line. The patient completed a positive Hawkin's test. The knee pain continues to be the patient's chief complaint but she will also need shoulder surgery. Treatment includes a Meniscectomy, Chondroplasty, Abrasion Arthroplasty, and Synovectomy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI Bilateral Ankle:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and Foot Complaints, Imaging MRI

**Decision rationale:** Per the CA MTUS/ACOEM, Chapter 14 Ankle and Foot complaints, page 374, magnetic resonance imaging may be helpful to clarify a diagnosis such as osteochondritis desiccans in cases of delayed recovery. According to the ODG criteria, Ankle and Foot Complaints, Imaging MRI, criteria includes workup with foot pain when plain films are negative. Based upon the clinical information submitted and the guidelines cited above, the decision is for not medically necessary for the request for the MRI of the ankle. There is insufficient evidence in the records of plain radiographs being obtained or suspicion of osteochondritis desiccans from the records of 6/17/14. Therefore, the determination is not medically necessary.

**Menisectomy, Chondroplasty, Abrasion Arthroplasty, Synovectomy, left:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 13 Knee Complaints Page(s): 209.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Chondroplasty

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of chondroplasty. According to the ODG Knee and Leg regarding chondroplasty, Criteria include conservative care, subjective clinical findings of joint pain, and swelling plus objective clinical findings of effusion or crepitus plus limited range of motion plus chondral defect on MRI. In this case, the MRI from 1/16/14 does not demonstrate a clear chondral defect on MRI nor does the exam note from 6/17/14 demonstrate objective findings consistent with a symptomatic chondral lesion. Therefore, the determination is not medically necessary.

**Associated Surgical Service: Post-Op PT x12 visits:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Chondroplasty

**Decision rationale:** As the requested Associated Surgical Service: Surgical Procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated Surgical Service: Pre-Op Medical Clearance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Chondroplasty

**Decision rationale:** As the requested Associated Surgical Service: Surgical Procedure is not medically necessary, none of the associated services are medically necessary and appropriate.