

Case Number:	CM14-0067262		
Date Assigned:	07/11/2014	Date of Injury:	11/21/2013
Decision Date:	09/19/2014	UR Denial Date:	05/02/2014
Priority:	Standard	Application Received:	05/12/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Texas and Ohio. 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 injured worker is a 52-year-old male who reported an injury on 11/21/2013 due to a fall. On 04/23/2014, the injured worker presented with ongoing catching in the right hip with recurrent groin pain. Upon examination of the bilateral knees, there was tenderness along the medial joint line and range of motion values was 0 to 115 degrees. The collateral and cruciate ligaments were stable. There was a positive McMurray's medially. Examination of the right hip revealed 10 degrees of internal and 10 degrees of external rotation with pain at the extremes and pain with resistance in all planes. The diagnoses were bilateral knee medial meniscal tear and right hip pain, probable labral tear. An x-ray of the bilateral knees dated 12/04/2013 revealed no obvious acute fracture or fixation. An MRI of the left knee dated 12/13/2013 revealed a commonly seen interstitial tear with distal quadriceps tendon and inflamed fat along superior aspect of the patella with increased T2 signal and small joint effusion and interstitial tears within the distal anterior cruciate ligament. There was a tear within the posterior horn of the medial meniscus extending to the inferior articular surface near the apex. An MRI of the right knee performed on 12/13/2013 revealed interstitial tear within the distal quadriceps tendon, marrow edema within the medial aspect of the patella and small joint effusion with interstitial tear within the anterior cruciate ligament with strain. There was a broad based oblique tear within the posterior horn of the medial meniscus which extends from the posterior free edge inferiorly to the apex. Prior therapies included injections and medications. The provider recommended a left knee arthroscopy with partial meniscectomy, right knee arthroscopy with partial meniscectomy and preoperative medical clearance. The provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Knee Arthroscopy with partial Meniscectomy: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Web Based version.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345.

Decision rationale: The request for left knee arthroscopy with partial meniscectomy is medically necessary. The California MTUS ACOEM Guidelines state arthroscopic partial meniscectomy usually has a high success rate for cases in which there is evidence of a meniscal tear with symptoms other than simply pain. The injured worker should have locking, popping, giving way or recurring effusion, clear signs of a bucket handle tear upon examination and consistent findings on MRI. However, injured workers suspected of having meniscal tears, but without progressive or severe activity limitation, may be encouraged to live with symptoms to retain the protective effect of the meniscus. If symptoms are lessening, conservative methods can maximize healing. In injured workers 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 injured workers who are exhibiting signs of degenerative changes. The clinical documentation noted tenderness along the medial joint lines at the bilateral knee and range of motion is 0 to 115 degrees. The collateral and cruciate ligaments were stable with a positive McMurray's medially. An MRI of the left knee revealed an interstitial tear within the distal anterior cruciate ligament and a tear within the posterior horn of the medial meniscus extending to the inferior articular surface near the apex. The injured worker has taken Advil and Tramadol. The guidelines would support surgical intervention for meniscectomy with clear objective documentation of pathology and diagnostic imaging, and limitations on examination with failure of conservative treatment. As such, the Left Knee Arthroscopy with partial Meniscectomy is medically necessary.

Right Knee Arthroscopy with Partial Meniscectomy: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Web Based Version.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345.

Decision rationale: The California MTUS ACOEM Guidelines state arthroscopic partial meniscectomy usually has a high success rate for cases in which there is evidence of a meniscal tear with symptoms other than simply pain. The injured worker should have locking, popping, giving way or recurring effusion, clear signs of a bucket handle tear upon examination and consistent findings on MRI. However, injured workers suspected of having meniscal tears, but

without progressive or severe activity limitation, may be encouraged to live with symptoms to retain the protective effect of the meniscus. If symptoms are lessening, conservative methods can maximize healing. In injured workers 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 injured workers who are exhibiting signs of degenerative changes. The clinical documentation noted tenderness along the medial joint lines at the bilateral knee and range of motion is 0 to 115 degrees. The collateral and cruciate ligaments were stable with a positive McMurray's medially. An MRI of the left knee revealed an interstitial tear within the distal anterior cruciate ligament and a tear within the posterior horn of the medial meniscus extending to the inferior articular surface near the apex. The injured worker has taken Advil and Tramadol. The guidelines would support surgical intervention for meniscectomy with clear objective documentation of pathology and diagnostic imaging, and limitations on examination with failure of conservative treatment. As such, a left knee arthroscopy with partial meniscectomy is medically necessary.

Preoperative Medical Clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Low Back, Preoperative Lab.

Decision rationale: The Official Disability Guidelines state preoperative testing is often performed for surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the injured worker's clinical history, comorbidities, and physical examination findings. Injured workers with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. An alternative to preoperative testing for the purposes of determining fitness for anesthesia, and identifying injured workers at high risk for postoperative complications through history and physical examination, with selective testing based on clinician's findings. The included medical documents lack evidence of physical exam findings and clinical history that would be indicative of high surgery risk for the injured worker. As such, Preoperative Medical Clearance is not medically necessary.