

<b>Case Number:</b>	CM13-0044431		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	04/12/2011
<b>Decision Date:</b>	03/13/2015	<b>UR Denial Date:</b>	10/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Minnesota, Florida  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 25-year-old female with an injury date of 4/12/2011. The mechanism of injury is not reported. On March 26, 2014 per an orthopedic examination she presented with complaints of low back pain and right knee pain. There was mild tenderness at L4-S1. Range of motion of the lumbosacral spine was limited. Examination of the right knee revealed positive medial McMurray and patellar grind test with crepitus but no instability. Range of motion was 0-140 degrees. Strength was 5/5. MRI of the right knee dated 8/7/2012 revealed blunting at the apex of the lateral meniscus, bone marrow edema along the lateral femoral condyle and medial tibial plateau. She was treated with physical therapy 12 sessions in May 2011, acupuncture September 2011, and TENS unit in September 2012. The diagnosis was low back pain, degenerative disc disease, lumbar spine, right knee pain, rule out meniscus tear. An MRI scan of the lumbar spine with and without load bearing was performed on March 31, 2014. The impression was central focal disc protrusion at L5-S1 that abuts the thecal sac. Posterior annular tear/fissure. The neural foramina were patent. Disc measurements: Pre-axial loading 2.8 mm; post axial loading: 2.9 mm. A repeat MRI scan of the lumbar spine dated 9/9/2014 revealed disc desiccation at L5-S1 with slight to moderate posterior disc space narrowing and a punctate area of annular compromise within its dorsal superior midline margin causing the disc to sag out in a wide-based fashion 2.5 mm into the central canal effacing the epidural fat and abutting the thecal sac but not distorting the S1 nerve roots. A 4.1 cm right ovarian cyst was present. A request for arthroscopic examination of the right knee with partial lateral meniscectomy was non-certified by utilization review on 10/23/2013 as there was no documentation of conservative care to the

knee since 2011, the MRI did not show any tear, the AME did not recommend any surgery. Recent evidence shows that the meniscus should be retained if possible. Meniscus surgery increases risk of osteoarthritis by 70%, and there was no evidence of locking, instability or mechanical symptoms. X-rays of the lumbar spine and right knee were also non-certified as there was no new injury and no red flag diagnoses. There was no neurologic deficit and there were prior MRI scans of the lumbosacral spine as well as right knee. This has now been appealed to an independent medical review.

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

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

#### **ARTHROSCOPIC EXAM OF THE RIGHT KNEE WITH PARTIAL LATERAL MENISCECTOMY OUTPATIENT: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE 2ND EDITION (2004), 116

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343, 344, 345.

**Decision rationale:** California MTUS guidelines indicate surgical considerations for 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. The available documentation does not indicate any recent exercise program for the knee. Arthroscopic partial lateral meniscectomy is indicated if symptoms other than simply pain such as locking, popping, giving way or recurrent effusion are present and if there is clear sign of bucket-handle tear on examination with tenderness over the suspected tear but not over the entire joint line and lack of full passive flexion, and consistent findings of a meniscal tear on the MRI scan. Such is not the case here. The MRI scan did not show a meniscal tear and no mechanical symptoms are documented. The guidelines also state that patients suspected of having meniscal tears but without progressive or severe activity limitation can be encouraged to live with symptoms to retain the protective effect of the meniscus. The MRI scan did not show any meniscus tear and so the request for arthroscopy is not supported. Shaving of patellar chondromalacia although performed frequently, has not been proven to be of any benefit. As such, the request for arthroscopic examination of the right knee with partial lateral meniscectomy is not supported and the medical necessity is not substantiated.

#### **X-RAYS A/P AND LATERAL LUMBAR BACK AND RIGHT KNEE: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints Page(s): 341, 343, 303.

**Decision rationale:** The clinical parameters for ordering radiographs following trauma are a joint effusion within 24 hours of direct blow or fall and palpable tenderness over the fibular head or patella. The injured worker already has had an MRI scan. Reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion. MRIs are superior to radiography which has no ability to identify and define soft tissue knee pathologies such as meniscus tear, ligament strain, tendinitis, prepatellar bursitis, or regional pain. The guidelines also indicate that lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology even if the pain has persisted for at least 6 weeks. The patient already had MRI scans of the lumbosacral spine and there is no question about the diagnosis. Therefore x-rays are not indicated at this time.