

<b>Case Number:</b>	CM14-0189416		
<b>Date Assigned:</b>	11/20/2014	<b>Date of Injury:</b>	12/07/2012
<b>Decision Date:</b>	01/08/2015	<b>UR Denial Date:</b>	10/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/13/2014

### 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:

According to the records made available for review, this is a 63-year-old female with a 12/7/12 date of injury. At the time (9/30/14) of the request for authorization for right knee arthroscopy with partial meniscectomy and possible chondroplasty, there is documentation of subjective (bilateral knee pain) and objective (patellar crepitus on flexion and extension bilaterally with medial and lateral joint line tenderness and positive McMurray's test) findings, imaging findings (MRI right knee (8/29/14) report revealed osteoarthritic changes of the knee, most prominently seen in the medial and patellofemoral compartments. Medial collateral ligament sprain. Horizontal cleavage tears of the posterior horn of the medial meniscus. Small Baker's cyst. Patellar tendinopathy), current diagnoses (internal derangement of knee and meniscal tear medial), and treatment to date (medication and cortisone injections). There is no documentation of symptoms other than simply pain (locking, popping, giving way, recurrent effusion) and clear signs of a bucket-handle tear on examination (tenderness over the suspected tear but not over the entire joint line, and perhaps lack of full passive flexion).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right knee arthroscopy with partial meniscectomy and possible chondroplasty:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Meniscectomy

**Decision rationale:** MTUS reference to ACOEM Guidelines identifies that arthroscopic partial meniscectomy usually has a high success rate for cases in which there is clear evidence of a meniscus tear; symptoms other than simply pain (locking, popping, giving way, recurrent effusion); clear signs of a bucket-handle tear on examination (tenderness over the suspected tear but not over the entire joint line, and perhaps lack of full passive flexion); and consistent findings on MRI, as criteria necessary to support the medical necessity of meniscectomy. ODG identifies documentation of conservative care (Physical therapy OR Medication OR Activity modification), at least two symptoms (Joint pain OR Swelling OR Feeling of give way OR Locking, clicking, or popping), at least two findings (Positive McMurray's sign OR Joint line tenderness OR Effusion OR Limited range of motion OR Locking, clicking, or popping OR Crepitus), and imaging findings (Meniscal tear on MRI), as criteria necessary to support the medical necessity of meniscectomy. Within the medical information available for review, there is documentation of diagnoses of internal derangement of knee and meniscal tear medial. In addition, there is documentation of consistent findings on MRI. However, despite documentation of subjective (bilateral knee pain) and objective (patellar crepitus on flexion and extension bilaterally with medial and lateral joint line tenderness and positive McMurray's test) findings, there is no documentation of symptoms other than simply pain (locking, popping, giving way, recurrent effusion) and clear signs of a bucket-handle tear on examination (tenderness over the suspected tear but not over the entire joint line, and perhaps lack of full passive flexion). Therefore, based on guidelines and a review of the evidence, the request for right knee arthroscopy with partial meniscectomy and possible chondroplasty is not medically necessary.