

<b>Case Number:</b>	CM14-0211352		
<b>Date Assigned:</b>	12/24/2014	<b>Date of Injury:</b>	11/04/2011
<b>Decision Date:</b>	02/17/2015	<b>UR Denial Date:</b>	12/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/16/2014

### 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 66-year-old female with an 11/4/11 date of injury. At the time (10/27/14) of the request for authorization for arthroscopic right partial medial meniscectomy, chondroplasty and debridement, associated surgical service: pre-operative medical clearance, associated surgical service: supervised post-operative rehabilitative therapy 3 times per week for 4 weeks, associated surgical service: continuous passive motion (CPM) device for an initial period of 14 days, associated surgical service: Surgi-Stim unit for an initial period of 90 days, then purchase, and associated surgical service: Coolcare cold therapy unit, there is documentation of subjective (pain level 10/10) and objective (flexion 120, extension 180, medial joint line tenderness) findings, imaging findings (MRI of the right knee (10/11/14) report revealed moderate-sized joint effusion. High-grade chondromalacia of the patellofemoral joint. Horizontal oblique tear of the posterior horn of the medial meniscus. Mild tricompartmental osteoarthritic changes. Mild chondromalacia of the medial compartment), current diagnoses (MRI scan-confirmed right medial meniscus tear, status post industrial trip-and-fall incident, November 4, 2011), and treatment to date (aquatic therapy, physiotherapeutic modalities and exercise, and medication). There is no documentation of at least one additional symptom (Swelling OR Feeling of give way OR Locking, clicking, or popping) and at least one additional finding (Positive McMurray's sign OR Effusion OR Limited range of motion OR Locking, clicking, or popping OR Crepitus).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopic right partial medial meniscectomy, chondroplasty and debridement:** Upheld

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

**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 buckethandle 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 right knee medial and lateral meniscal tears and underlying osteoarthritis. In addition, there is documentation of conservative care (physical therapy and medication), at least one symptom (joint pain), at least one finding (joint line tenderness), and imaging findings (Meniscal tear on MRI). However, there is no documentation of at least one additional symptom (Swelling OR Feeling of give way OR Locking, clicking, or popping) and at least one additional finding (Positive McMurray's sign OR Effusion OR Limited range of motion OR Locking, clicking, or popping OR Crepitus). Therefore, based on guidelines and a review of the evidence, the request for arthroscopic right partial medial meniscectomy, chondroplasty and debridement is not medically necessary.

**Associated surgical service: pre-operative medical clearance:** 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.

**Associated surgical service: supervised post-operative rehabilitative therapy 3 times per week for 4 weeks:** 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.

**Associated surgical service: continuous passive motion (CPM) device for an initial period of 14 days:** 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.

**Associated surgical service: Surgi-Stim unit for an initial period of 90 days, then purchase:** 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.

**Associated surgical service: Coolcare cold therapy unit:** 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.