

Case Number:	CM15-0139744		
Date Assigned:	07/29/2015	Date of Injury:	10/22/2014
Decision Date:	09/01/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/20/2015

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 was a 64 year old male, who sustained an industrial injury, October 22, 2014. The injury was sustained when the injured worker stepped off a step and had twisting injury to the left knee and has since had medial sided knee pain. The injured worker previously received the following treatments Gabapentin, Meloxicam, Fluticasone propionate, Xarelto, Protonix, Atrovastatin, Montelukast sodium, Hydrocodone, Glycopyrrolate and left knee MRI. The injured worker was diagnosed with left knee pain and left knee meniscal tear. A physical examination of the left knee dated 3/4/2015 documented a normal gait. There was diffuse tenderness anteromedially with crepitus on range of motion. Patellar grind was positive but McMurray was negative. According to progress note of May 5, 2015, the injured worker's chief complaint was left knee pain. The physical exam noted left knee tenderness with palpation along the medial joint line with a positive McMurray's. There was a minimal effusion. The knee was ligamentously stable with a negative Lachman and negative posterior drawer. The injured worker had full range of motion of the knee from 0-130 degrees. The left knee MRI demonstrated a tear involving the posterior horn of the medial meniscus. The treatment plan included left knee arthroscopic surgery for medial meniscus debridement and postoperative physical therapy for the left knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic medial meniscus debridement, left knee: 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): 343, 344, 345.

Decision rationale: Per progress notes dated 7/23/2015, the injured worker is a 64-year-old male with a date of injury of 10/22/2014. He stepped wrong with his left knee and experienced pain. He completed several sessions of physical therapy without benefit. An MRI scan showed a tear of the posterior horn of the medial meniscus. He was taking Vicodin for pain and arthritis. The significant problems in the medical history include osteoarthritis, obesity, nephrolithiasis, atrial fibrillation and arteriosclerotic heart disease. There was an atrophic kidney documented. Examination of the left knee revealed tenderness to palpation along the medial joint line, positive McMurray, minimal effusion, no instability, and full range of motion. He was 71 inches tall and weighed 265 pounds. BMI was 36.96. In the MRI report pertaining to the left knee is dated 1/5/2015. The findings included subchondral cyst formation along the lateral aspect of the medial femoral condyle. A small knee effusion was identified. There was a tear of the posterior horn of the medial meniscus. The lateral meniscus was intact. The anterior cruciate ligament was intact. The posterior cruciate ligament demonstrated mildly increased intrasubstance signal consistent with low-grade sprain. Weightbearing films demonstrating narrowing of the joint space have not been submitted. Physical therapy notes dated 11/19/2014 document subjective complaints of pain behind the knee and in the knee cap if I step wrong. PT notes from 11/24/2014 indicate the injured worker had attended 5 of 6 prescribed visits with no difference in the pain. There was also evidence of osteoarthritis of the hip. The diagnosis on the physical therapy notes of 11/24/2014 was lumbar disc displacement. Subjective complaints included cramping in the leg including the thigh and calf, etc. The notes indicate that the therapy focused on quad strength, hip stability while avoiding flexion to prevent knee derangement. To summarize, the injured worker is obese and there is a history of osteoarthritis which probably involves the hips and possibly also the knee with evidence of subchondral cyst formation on the MRI. There is also a history of low back issues per PT report. The subjective complaints included cramping in the thigh as well as calf and pain in the kneecap as well as in the popliteal area. The documentation indicates 5 sessions of physical therapy in the year 2014 which concentrated on quadriceps strengthening and hip stability. The diagnosis was lumbar disc displacement. Weightbearing x-rays of the left hip and knee have not been obtained. Corticosteroid injections of the left knee have not been documented. The available history does not include mechanical symptoms such as locking, popping, or giving way. And there is no recent physical therapy documented in 2015 pertaining to the left knee. A physical examination of the left knee dated 3/4/2015 documented a normal gait. There was diffuse tenderness anteromedially with crepitus on range of motion. Patellar grind was positive but McMurray was negative. In light of the documentation of osteoarthritis of the hip on the old PT notes, referred pain to the knee joint is a possibility. California MTUS guidelines indicate arthroscopic partial meniscectomy is indicated when there is clear evidence of a symptomatic meniscal tear such as locking, popping, giving way, or recurrent effusion and clear sign of a bucket handle tear on examination. 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. Arthroscopy and meniscus surgery may not be equally beneficial for those patients who are exhibiting signs of degenerative changes. In this case, no mechanical symptoms have been documented. The pain in the knee could be referred pain from the hip as the injured worker

has cramping of the thigh as well as calf and the PT notes document osteoarthritis of the hip. Radicular pain from the lumbar area is also not ruled out. In light of the history of degenerative changes including the subchondral cyst formation noted on the MRI scan, a corticosteroid / lidocaine injection into the knee as a diagnostic/therapeutic trial would be of benefit. California MTUS guidelines indicate surgical considerations for failure of exercise programs to increase range of motion and strength of the musculature around the knee. The documentation does not indicate any recent exercise rehabilitation program for the left knee. As such, the request for arthroscopy of the left knee is not supported and the medical necessity of the request has not been substantiated.

Post-operative physical therapy, 3 times weekly, left knee Qty: 24: 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.