MAXIMUS Federal Services

Case Number:	CM15-0139830		
Date Assigned:	07/29/2015	Date of Injury:	07/08/2011
Decision Date:	08/26/2015	UR Denial Date:	06/22/2015
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: California, Oregon, Washington
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 57-year-old male who sustained a work related injury July 8, 2011. A primary treating physician's follow-up examination, dated April 14, 2014, found the injured worker presenting with low back pain rated 6-7 out of 10 and left knee pain rated 9 out of 10. Examination of the left knee revealed; tenderness in the medial and lateral joint lines; flexion right 120 degrees and left 110 degrees and extension 0 degrees right and left; patellofemoral crepitus noted and McMurray's test with internal rotation is positive on the left knee. Assessment is documented as right shoulder impingement; lumbar spine disc protrusion; lumbar radiculitis; left knee internal derangement; left knee osteoarthritis with instability. Treatment plan included a request for authorization for arthroscopy with repair, left knee. A Sestamibi stress test with spect imaging, dated June 20, 2014, revealed anterior, apical, and inferior wall ischemia and ejection fraction 20%. Past history included coronary artery disease with stenting 2005 and 2014, hypertension, diabetes mellitus, hypercholesterolemia, atrial fibrillation, and obstructive sleep apnea. A cardiology consultation, dated June 20, 2014, is for consideration for a left knee arthroscopic surgery and debridement. The injured worker is on anticoagulation and anti-platelet therapy and does not appear to be in pulmonary edema at this time. He is not able to clear for surgery until past medical records are reviewed regarding catheterization and evaluation of all testing.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopy with repair, left knee, per 04/14/14 order: 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), Knee & Leg (update 05/05/15) - Online Version.

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) Meniscectomy section.

Decision rationale: CA MTUS/ACOEM Chapter 13 Knee Complaints, pages 344-345, states regarding meniscus tears, "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)." According to ODG Knee and Leg section, Meniscectomy section, states indications for arthroscopy and meniscectomy include attempt at physical therapy and subjective clinical findings, which correlate with objective examination and MRI. In this case, the exam notes from 4/14/2014 do not demonstrate evidence of adequate course of physical therapy or other conservative measures. In addition, there is lack of evidence in the cited records of meniscal symptoms such as locking, popping, giving way or recurrent effusion. Therefore, the determination is not medically necessary.