

<b>Case Number:</b>	CM15-0207328		
<b>Date Assigned:</b>	10/26/2015	<b>Date of Injury:</b>	06/15/2012
<b>Decision Date:</b>	12/15/2015	<b>UR Denial Date:</b>	10/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2015

### 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:

This is a 44 year old male with a dated of injury on 6-15-12. A review of the medical records indicates that the injured worker is undergoing treatment for left knee pain. Progress report dated 9-29-15 reports continued complaints of left knee pain despite conservative care and 2 previous left knee arthroscopic surgeries. Physical exam: left knee medial tenderness with mildly positive Steinman's and McMurrays, non-crepitus with range of motion. MRI was mentioned to show a horizontal cleavage tear of the lateral meniscus. Treatments in the past have included: medication, physical therapy, cold therapy, and left knee arthroscopic surgery x 2. Request for authorization dated 10-2-15 was made for Arthroscopy, left knee, surgical with meniscus repair, (medial or lateral) and Arthroscopy, left knee, surgical with meniscectomy-chondroplasty. Utilization review dated 10-8-15 non-certified the request as there was no recent comprehensive non-operative treatment protocol with trial / failure.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopy, left knee, surgical with meniscus repair, (medial or lateral), Qty 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee & Leg (Acute & Chronic) - Indications for surgery.

**MAXIMUS guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** The injured worker is a 44-year-old male with a history of 2 prior arthroscopic surgeries on his left knee in 2013 and 2014 consisting of partial lateral meniscectomies. There is documentation of low back pain with radiculopathy and bilateral total hip arthroplasties. He complains of left knee pain and has frequent episodes of clicking and popping but no catching or locking has been described. The last surgery was on July 7, 2014 and resulted in a small fistula over the medial portal site which required additional treatment with antibiotics and delayed closure. He also underwent 3 arthroscopic surgeries on his right knee in 2008, 2010, and 2013. The orthopedic examination of September 29, 2015 documented tenderness over the medial joint line with a mildly positive Steinmann's and McMurray's. There was mild tenderness over the lateral joint line as well. The most recent MRI scan is dated June 12, 2015 and shows a horizontal oblique tear of the body of the lateral meniscus violating the inferior meniscal surface. The medial meniscus was intact. There was a 3 mm near full-thickness chondral defect in the median ridge of the patella. A standing x-ray of the same knee dated 6/28/2015 revealed minimal tricompartmental degenerative changes and mixed lysis and sclerosis in the femoral condyle suggesting osteonecrosis which was not noted on the MRI scan. Per AME of August 9, 2015 the two prior surgical procedures included a partial lateral meniscectomy followed by a revision partial lateral meniscectomy. The prior MRI scan dated 4/24/2014 showed the same oblique linear signal in the body of the lateral meniscus which was unchanged from 2009. Patellar chondromalacia was also noted. The AME recommended injections and an exercise program. California MTUS guidelines indicate 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 such as locking, popping, giving way and recurrent effusion, clear signs of a bucket handle tear on examination with tenderness over the suspected tear but not over the entire joint line, lack of full flexion and consistent findings on MRI. In this case there is an oblique linear signal in the lateral meniscus that has been present since 2009 although it appears a bit worse now. The injured worker had undergone 2 arthroscopic surgeries for this in 2013 and 2014 without significant long-term improvement. Although partial lateral meniscectomies were performed, the major portion of the body of the lateral meniscus was not removed as the findings indicated that it was stable. The documentation from September 29, 2015 indicates tenderness over the medial joint line with a mildly positive Steinmann's and McMurray's. This does not meet the guideline necessitated requirement of tenderness over the tear but not the entire joint line. The other finding is that of chondromalacia involving the patella and evidence of minimal tricompartmental degenerative joint disease on the standing films as documented on radiology reports in June. Utilization review non-certified the request for surgery as there was no recent comprehensive non-operative treatment program documented with exercise rehabilitation and corticosteroid injections. Review of the medical records does not indicate a recent specific comprehensive non-operative treatment protocol with trial/failure pertaining to the left knee. As such, the medical necessity of the surgical procedure of meniscus repair is not established.

**Arthroscopy, left knee, surgical with meniscectomy/chondroplasty, Qty 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee & Leg (Acute & Chronic) - Indications for surgery, Knee meniscectomy.

**MAXIMUS guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** The injured worker is a 44-year-old male with a history of 2 prior arthroscopic surgeries on his left knee in 2013 and 2014 consisting of partial lateral meniscectomies. There is documentation of low back pain with radiculopathy and bilateral total hip arthroplasties. He complains of left knee pain and has frequent episodes of clicking and popping but no catching or locking has been described. The last surgery was on July 7, 2014 and resulted in a small fistula over the medial portal site which required additional treatment with antibiotics and delayed closure. He also underwent 3 arthroscopic surgeries on his right knee in 2008, 2010, and 2013. The orthopedic examination of September 29, 2015 documented tenderness over the medial joint line with a mildly positive Steinmann's and McMurray's. There was mild tenderness over the lateral joint line as well. The most recent MRI scan is dated June 12, 2015 and shows a horizontal oblique tear of the body of the lateral meniscus violating the inferior meniscal surface. The medial meniscus was intact. There was a 3 mm near full-thickness chondral defect in the median ridge of the patella. A standing x-ray of the same knee dated 6/28/2015 revealed minimal tricompartmental degenerative changes and mixed lysis and sclerosis in the femoral condyle suggesting osteonecrosis which was not noted on the MRI scan. Per AME of August 9, 2015 the two prior surgical procedures included a partial lateral meniscectomy followed by a revision partial lateral meniscectomy. The prior MRI scan dated 4/24/2014 showed the same oblique linear signal in the body of the lateral meniscus which was unchanged from 2009. Patellar chondromalacia was also noted. The AME recommended injections and an exercise program. California MTUS guidelines indicate 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 such as locking, popping, giving way and recurrent effusion, clear signs of a bucket handle tear on examination with tenderness over the suspected tear but not over the entire joint line, lack of full flexion and consistent findings on MRI. In this case there is an oblique linear signal in the lateral meniscus that has been present since 2009 although it appears a bit worse now. The injured worker had undergone 2 arthroscopic surgeries for this in 2013 and 2014 without significant long-term improvement. Although partial lateral meniscectomies were performed, the major portion of the body of the lateral meniscus was not removed as the findings indicated that it was stable. The documentation from September 29, 2015 indicates tenderness over the medial joint line with a mildly positive Steinmann's and McMurray's. This does not meet the guideline necessitated requirement of tenderness over the tear but not the entire joint line. The other finding is that of chondromalacia involving the patella and evidence of minimal tricompartmental degenerative joint disease on the standing films as documented on radiology reports in June. Utilization review non-certified the request for surgery as there was no recent comprehensive non-operative treatment program documented with exercise rehabilitation and corticosteroid injections. Review of the medical records does not indicate a specific comprehensive non-operative treatment protocol with trial/failure pertaining to the left knee. As such, the medical necessity of the surgical procedure of meniscectomy / chondroplasty is not established.