

<b>Case Number:</b>	CM15-0209666		
<b>Date Assigned:</b>	10/28/2015	<b>Date of Injury:</b>	12/06/2007
<b>Decision Date:</b>	12/18/2015	<b>UR Denial Date:</b>	10/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/26/2015

### 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 is a 55 year old male with an industrial injury date of 12-06-2007. Medical record review indicates he is being treated for post lumbar laminectomy syndrome, low back pain and knee pain (08-19-2015). He presented on 10-06-2015 for "evaluation and treatment of a 3 year history of bilateral, right greater than left, medial and posterior knee pain." The injured worker reported limitations in his range of motion of the knee. "His symptoms do interfere with daily activities and desired function." Objective findings are not indicated in the 10-06-2015 note. In the treatment note dated 08-19-2015 examination of both knee joints revealed no deformity, swelling, quadriceps atrophy, asymmetry or misalignment. Range of motion was restricted with flexion limited to 120 degrees. Crepitus was not noted with active movement. Tenderness to palpation was noted over the medial joint line. Medications (08-19-2015) included Lunesta, Soma, Viagra, Paxil and Wellbutrin. Prior medications included Fentanyl (stopped due to itching and problems in urination). The injured worker had intrathecal pump in place. Prior treatment included activity modification, medications, physical therapy and steroid injection. On 10-15-2015 the request for right knee partial meniscectomy and chondroplasty was non-certified by utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right knee partial meniscectomy and chondroplasty:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg - Chondroplasty.

**MAXIMUS guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation ODG: Section: Knee, Topic: chondroplasty.

**Decision rationale:** The injured worker is a 55-year-old male with a date of injury of 12/6/2007. The documentation includes a radiology reports pertaining to x-rays of both knees which does not mention if the films were weightbearing. The report is dated 5/4/2015 and shows mild right medial femoral tibial compartment narrowing with slight lateral translocation of the right tibia, osteophyte formation along the left medial joint line and the medial aspect of the left patellofemoral joint and at the upper pole of the patella with no suprapatellar joint effusion identified. On the left side there was spurring along the posterior joint line of the tibia and anteriorly as well. No recent standing films or MRI scan has been provided. A request for authorization dated April 22, 2015 is requesting a consultation for possible right total knee arthroplasty. A subsequent note of 10/6/2015 indicates bilateral knee pain, right greater than left for 3 years. He was reporting limitation in his range of motion of the knee. No mechanical symptoms were documented. He was last seen 2 years before and at that time was appropriate for arthroscopy. However, he was unable to undergo the surgery because of his back. The second page of the notes including the examination findings is missing. The documentation does not indicate any recent nonoperative treatment for the knee. The plan was arthroscopic partial meniscectomy and chondroplasty of the right knee. California MTUS guidelines indicate surgical considerations for activity limitation for more than one month and failure of exercise programs to increase range of motion and strength of the musculature around the knee. 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 recurrent effusions, 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. However, patients suspected of having meniscus 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, there is no recent imaging study submitted. X-rays from 5/4/2015 showed mild medial compartment narrowing and osteophytosis in the medial compartment as well as patellofemoral joint. In the absence of updated diagnostic studies and evidence of a recent comprehensive nonoperative treatment protocol with physical therapy and corticosteroid injections, the requested arthroscopy with partial medial meniscectomy is not reasonable and medically necessary at this time. With regard to the request for chondroplasty, ODG guidelines necessitate the presence of a chondral defect and absence of chondromalacia. In the absence of a recent imaging study demonstrating the need for such a procedure, the request for chondroplasty is not supported and the medical necessity of the request has not been substantiated. Therefore, the requested treatment is not medically necessary.