

<b>Case Number:</b>	CM15-0027607		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	10/28/2014
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2015

### 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  
 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 22-year-old male who reported injury on 10/28/2014. The mechanism of injury was the injured worker pushed a car 3 quarters of the way back to the shop before 2 coworkers came to his assistance. The injured worker had heard a pop in his right knee. Surgical history was not provided. The documentation of 01/13/2015 revealed the injured worker was in the office for a recheck of the right knee and to review the MRI. The injured worker had frank buckling and instability with and without a knee brace and the injured worker was cane dependent. The injured worker was utilizing tramadol, which provided minimal relief. The injured worker had an antalgic gait. The injured worker had a limited heel and toe rise. The injured worker had 1+ effusion and synovitis and tenderness in the medial joint line and lateral joint line as well as the patella. The left range of motion was 0 degrees. The injured worker had subpatellar crepitation of 1+, a positive anterior drawer sign, and a positive pivot shift and Lachlan's test in the right knee. The injured worker was walking with a cane. Lower extremity sensation was intact. The injured worker was noted to undergo an x-ray. The x-ray, 4 views, of the right knee on 12/02/2014 revealed a 2 to 3+ patellar tilt and minimal axial changes. The injured worker underwent an x-ray of the right knee, 3 views, on 12/29/2014, which revealed no fracture or dislocation. The injured worker was noted to undergo an MRI of the right knee on 01/13/2015, which revealed a partial medial meniscus tear and tib/fib proximal joint osteoarthritis and the films for grade IIC MMT in 3 cuts. The injured worker had 2+ PLC gutter sign and edema with moderate PLB ACL edema. The impression was subchondral cystic changes and marrow edema along the superior tibiofibular joint, suggesting osteoarthritis. The

diagnoses included knee synovitis, effusion of the knee joint, knee instability, and joint pain, left leg. The treatment plan and discussion included the injured worker had failed conservative treatment including activity modification, bracing, cane use, home therapy, and the MRI was consistent with grade IIC medial meniscus tear. The examination was noted to be consistent with a meniscus tear, PFS, and PLC laxity. The documentation indicated the injured worker was a candidate for knee arthroscopy with meniscus surgery to return to gainful employment. As such, the request was made for surgical intervention. There was a Request for Authorization submitted for review dated 02/11/2015. The official MRI was not provided for review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Posterior Lateral Corner Surgery: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343 and 345.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicates that a surgical consultation may be appropriate for an injured worker who has activity limitations for more than 1 month and failure of an exercise program to increase range of motion and strength of the musculature around the knee. Additionally, they indicate that anterior cruciate ligament reconstruction is warranted for injured workers who have significant symptoms of instability caused by ACL incompetence, and that a meniscus tear repair is appropriate when there are symptoms other than pain including locking, popping, giving way, and recurrent effusion, clear signs of a bucket handle tear on examination, and consistent findings on MRI. The clinical documentation submitted for review indicated the injured worker had a failure of conservative care. Additionally, there was documentation the injured worker had instability upon physical examination. However, there was no official MRI submitted for review to support a necessity for the requested surgical intervention. Given the above, the request for Posterior Lateral Corner Surgery is not medically necessary.

#### **Right Knee Arthroscopy, Medial and Lateral Meniscus Surgery, Patellofemoral: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343 and 345.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicates that a surgical consultation may be appropriate for an injured worker who has activity limitations for more than 1 month and failure of an exercise program to increase range of motion and strength of the musculature around the knee. Additionally, they indicate that anterior cruciate ligament reconstruction is warranted for injured workers who have significant symptoms of

instability caused by ACL incompetence, and that a meniscus tear repair is appropriate when there are symptoms other than pain including locking, popping, giving way, and recurrent effusion, clear signs of a bucket handle tear on examination, and consistent findings on MRI. The clinical documentation submitted for review indicated the injured worker had a failure of conservative care. Additionally, there was documentation the injured worker had instability upon physical examination. However, there was no official MRI submitted for review to support a necessity for the requested surgical intervention. Given the above, the request for Right Knee Arthroscopy, Medial and Lateral Meniscus Surgery, Patellofemoral is not medically necessary.

**Post-operative Cold Therapy Unit (Purchase or 14 day rental): 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), Treatment Index, 11th Edition, 2014, Continuous-flow cryotherapy.

**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.

**Post-operative Knee Brace (Purchase): 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); Treatment Index, 11th Edition, Knee & Leg/ Knee Brace.

**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.

**Pre-operative EKG: 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) Treatment in Workers Compensation, Online Edition, Chapter Low Back-Lumbar & Thoracic (Acute & Chronic).

**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.

**Post-operative Physical Therapy (3 times per week for 4 weeks): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**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.