

Case Number:	CM15-0210591		
Date Assigned:	10/29/2015	Date of Injury:	12/31/2013
Decision Date:	12/22/2015	UR Denial Date:	09/30/2015
Priority:	Standard	Application Received:	10/27/2015

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 43 year old male, who sustained an industrial-work injury on 4/11/2012. A review of the medical records indicates that the injured worker is undergoing treatment for the right knee. Treatment to date has included pain medication, injection to right knee, diagnostics, rest, ice, physical therapy, home exercise program (HEP), arthroscopic surgery x 2 (12/04/2012 and 9/12/2014), and other modalities. Medical records dated 6-25-15 indicate that the injured worker complains of ongoing right knee pain that increases with activities. He is able to walk for 15 to 20 minutes and then develops increased pain in the right knee. Per the treating physician report dated 6-25-15 the injured worker may do modified work duties. The physical exam dated 6-25-15 reveals slight effusion of the right knee, discomfort on McMurray's testing, crowding the medial compartment is painful, and the range of motion is 5-120 degrees. The history and physical dated 9-22-15 reveals that the injured worker complains of persistent right knee pain and weakness. The planned procedure is arthroscopy of the right knee. Magnetic resonance imaging (MRI) of the right knee dated 6-15-15 reveals normal study. The request for authorization date was 9-22-15 and requested service included Right knee arthroscopy with medial and lateral meniscectomy, synovectomy and debridement. The original Utilization review dated 9-30-15 non-certified the request for Right knee arthroscopy with medial and lateral meniscectomy, synovectomy and debridement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right knee arthroscopy with medial and lateral meniscectomy, synovectomy and debridement: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg.

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

Decision rationale: The injured worker is a 43-year-old male with a date of injury of 4/11/2012. The initial imaging studies revealed a tear in the right medial meniscus and mucoid degeneration of the anterior cruciate ligament. The injured worker failed nonoperative treatment and underwent arthroscopy with debridement, plica excision and loose body removal on 10/4/2012. A second arthroscopic procedure was performed on 9/12/2014 consisting of partial medial meniscectomy, synovectomy of the medial compartment and intercondylar notch. There is an AME from [REDACTED] dated April 30, 2015 according to which he was having continuing problems and it was suggested that he do light duty work with a desk job and inability to flex and extend his knee and to sit and stand ad lib. He should have minimal requirements to walk and should not be on his feet for any prolonged period of time. No prolonged standing, repetitive bending, stooping or kneeling was advised. A subsequent MRI scan of the right knee dated 6/15/2015 was interpreted by the radiologist as normal. Progress notes from June 25, 2015 document continuing right knee pain going from the inferior medial parapatellar region proximal to the superior portion of the medial parapatellar region. He was able to walk for 10-20 minutes and then developed increasing pain in the right knee. On examination his gait pattern was slowed. There was a slight effusion. No instability. Discomfort on McMurray testing. Crowding the medial compartment was painful. Range of motion was 5-120 degrees. No crepitation at the patellofemoral joint. A recent right knee MRI with contrast dated 6/15/2015 was a normal study per radiologist. There is a request for authorization dated 9/22/2015 for right knee arthroscopy, medial and lateral meniscectomy, synovectomy and debridement. The diagnosis was medial and lateral meniscal tears, synovitis, and chondromalacia of right knee. The surgical history and physical dated 9/22/2015 indicates the chief complaint of right knee pain with occasional giving way and weakness. On examination the surgical site was clean and dry. The justification for surgery was persistent right knee pain and weakness. Although surgery was scheduled for 10/22/2015, the documentation submitted does not indicate the rationale or the diagnostic study on the basis of which additional surgery was recommended. The request was noncertified by utilization review based upon the radiology report and absence of mechanical symptoms. 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 effusions, clear signs of a bucket handle tear on examination with 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 meniscal tears but without progressive or severe activity limitation can be encouraged to live with symptoms to retain the protective effect of the meniscus. In this case, there is no objective MRI report documenting meniscal tears. The MRI scan of 6/15/2015

was a normal study according to the Radiologist. The examination findings of 6/25/2015 documented inferior medial parapatellar pain radiating to the superior portion of the medial parapatellar region and not over the meniscus for which surgery is requested. Although a second opinion physician has read the MRI scan differently, there is no official document submitted from a radiologist indicating the difference. With regard to chondromalacia, the guidelines do not recommend patellar shaving as long-term improvement has not been proved and its efficacy is questionable. Based upon the documentation submitted, evidence-based guidelines do not support the requested additional surgery. As such, the request is not medically necessary.