

Case Number:	CM15-0212188		
Date Assigned:	11/02/2015	Date of Injury:	06/11/2015
Decision Date:	12/23/2015	UR Denial Date:	10/16/2015
Priority:	Standard	Application Received:	10/28/2015

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 61 year old female, who sustained an industrial injury on 6-11-2015. The injured worker was diagnosed as having left knee sprain and derangement of medial meniscus of left knee. Treatment to date has included diagnostics, bracing, physical therapy, and medications. On 10-08-2015, the injured worker complains of left knee pain and discomfort, "moderate intermittent". She wished to proceed with knee arthroscopy. Objective findings for the left knee noted "decreased range of motion" and medial joint line tenderness. Function with activities of daily living was not described. Treatment progress was "unchanged" from previous visit. Treatment was noted as nonsteroidal anti-inflammatory drugs and physical therapy, and bracing. Magnetic resonance imaging of the left knee (8-25-2015) showed evidence for popliteal cyst, minimal joint fluid, mild prepatellar bursitis, grade 2 MCL sprain, suggestion minimal distal ACL sprain, and small appearance of the body of the medial meniscus with some degree of signal changes, possibly related to tear versus degenerative change. Work status was modified. On 10-16-2015 Utilization Review non-certified a request for left knee arthroscopy with meniscectomy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left knee arthroscopy with meniscectomy: Overturned

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

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

Decision rationale: Per consulting physicians report dated 9/28/2015 the injured worker is a 61-year-old female who sustained no particular knee injury but had onset of pain on 6/11/2015 while working as a cashier. She moved a certain way and felt insidious onset of pain in her left knee on the medial aspect. Since that time she has pain with twisting, walking, squatting which is nearly impossible and even certain sleeping positions. There is a history of swelling with activity but she denies catching, locking, or giving way. On examination she had full range of motion in the knee and no effusion. Lateral patellar glide was 2+ and medial patellar glide also 2+. Patellar tilt was neutral. There was no instability. Examination of the medial meniscus revealed joint line tenderness of marked degree with marked increase in pain with the Flick test. McMurray was not tested due to pain. Apley was not tested due to pain. There was no joint line tenderness on the lateral aspect. She was unable to squat due to pain. She had pain with twisting. X-rays revealed well preserved joint space with minimal to no arthritic changes. MRI was consistent with posterior horn medial meniscal tear. The official report documents evidence for a popliteal cyst, minimal joint fluid, a mild prepatellar bursitis, grade 2 medial collateral ligament sprain, suggestion of minimal distal anterior cruciate ligament sprain, and small appearance of the body of the medial meniscus with some degree of signal changes which might be related to tear versus degenerative change. The consultant opined that the pain was likely due to a medial meniscal tear. She had exhausted nonoperative treatment and at this time arthroscopy was discussed. A request for surgery was noncertified by utilization review as there was no documentation of nonoperative treatment. Since that time documentation of extensive nonoperative treatment with physical therapy has been provided. According to California MTUS guidelines, 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 effusion, 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 the MRI scan. The guidelines also state that if symptoms are lessening conservative methods can maximize healing. In this case, the symptoms do not seem to be lessening despite the conservative therapy. The provider is documenting tenderness over the medial meniscus but not at the entire joint line. The physical examination supports the diagnosis of a medial meniscal tear involving the posterior horn, which is seen on the MRI scan as well. However, the tear is not causing any popping, catching, or locking at this point. The provider did not find any evidence of chondromalacia on examination to support the possible diagnosis of a degenerative change in the meniscus. Extensive conservative treatment has been tried including physical therapy, medications, bracing, etc. and the injured worker continues to be symptomatic. As such, the request for arthroscopy with partial medial meniscectomy is supported and is medically necessary.