

<b>Case Number:</b>	CM15-0030753		
<b>Date Assigned:</b>	02/25/2015	<b>Date of Injury:</b>	06/11/2002
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2015

### 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 71-year-old female who reported injury on 06/11/2002. The mechanism of injury was the injured worker was beat up. The diagnoses included internal derangement of the knee NOS. The documentation of 11/17/2014 revealed the injured worker had persistent pain in the left knee. The injured worker was noted to have pain that was worse in the morning. The physical examination revealed tenderness in the left knee with swelling. The x-ray revealed 1 mm articular surface. The injured worker was utilizing a DonJoy brace. The treatment plan included a prescription for MS Contin 30 mg #60, Percocet 10/325 mg #120 and Flexeril 7.5 mg for muscle spasms. Additionally, the injured worker was noted to have a prescription for an MRI of the left knee. The documentation indicated a request had been made for surgical intervention, including a left knee arthroscopy; meniscectomy; chondroplasty; preop clearance; 21 day rental of Polar Care; purchase of crutches and knee orthosis, adjustable; Augmentin 875/125 mg #20; Zofran 8 mg; and Neurontin 600 mg #180 postoperative.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Knee Arthroscopy, Meniscectomy, Chondroplasty: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Indications for Surgery Meniscectomy and Indications for Surgery Chondroplasty.

**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 indicate surgical intervention is appropriate for injured workers who have a failure of an exercise program to increase range of motion and strength of musculature around the knee and activity limitation for more than 1 month. There should be documentation of clear signs of bucket handle tear on examination and symptoms other than pain including locking, popping, giving way or current effusion. Additionally, there should be documentation of consistent findings on MRI. There was no MRI submitted for review. There were no objective findings upon physical examination, including clear signs of a bucket handle tear. There was a lack of documentation of a failure of conservative care. Given the above, the request for left knee arthroscopy, meniscectomy, and chondroplasty is not medically necessary.

**Associated Surgical Service: Polar Care Unit rental (21 days): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

**Associated Surgical Service: Crutches (purchase): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

**Amoxclavulanate (Augmentin) 875/124 mg QTY 20: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

**Zofran 8mg QTY 20:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

**Neurontin 600 mg QTY 180:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 medical clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

**Associated Surgical Service: Adjustable Knee Orthosis (purchase):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.