

Case Number:	CM15-0044742		
Date Assigned:	03/16/2015	Date of Injury:	09/24/2014
Decision Date:	04/20/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	03/09/2015

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: Illinois, California, Texas
 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 30-year-old female who sustained an industrial injury on 9/24/14. Injury occurred when she felt and heard a right knee pop while jumping on a trampoline at a company function. The 9/25/14 right knee MRI impression documented a complete tear of the anterior cruciate ligament (ACL), possible old posterior cruciate ligament tear, and probable grade 1 sprain of the medial and lateral collateral ligaments. There was a horizontal tear of the medial meniscus. Findings documented that the lateral meniscus was normal and no articular cartilage abnormalities were visualized. Conservative treatment included oral medications, 19 visits of physical therapy, bracing, and home exercise program. The 2/2/15 treating physician report cited bilateral knee pain. She had achieved full right knee range of motion with therapy and home exercise, but there was a sense of instability with any twisting or pushing for activities. Right knee range of motion was 0-130 with positive Lachman's, anterior drawer, and pivot shift tests. There was some slight quadriceps atrophy. Authorization was requested for right arthroscopic medial meniscectomy, lateral meniscectomy, chondroplasty, possible microfracture, and ACL reconstruction. The 2/12/15 utilization review modified the request for right arthroscopic medial meniscectomy, lateral meniscectomy, chondroplasty, possible microfracture, and ACL reconstruction and approved the request for right arthroscopic medial meniscectomy and anterior cruciate ligament reconstruction. The lateral meniscectomy, chondroplasty, and microfracture requests were denied as there were no objective findings or diagnostic studies that would establish medical necessity for these procedures.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Lateral Meniscectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Knee Chapter, Low back chapter.

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

Decision rationale: The California MTUS guidelines state that surgical consideration may be indicated for patients who have 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. Guidelines support arthroscopic partial meniscectomy for cases in which there is clear evidence of a meniscus tear including symptoms other than simply pain (locking, popping, giving way, and/or recurrent effusion), clear objective findings, and consistent findings on imaging. Guideline criteria have not been met. This patient presents with imaging evidence of a complete ACL tear and horizontal tear of the medial meniscus and is pending surgical correction of these tears. There is no current clinical exam or imaging evidence of a lateral meniscus tear to support the medical necessity of this request. Therefore, this request is not medically necessary.

Chondroplasty: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Knee chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg: Chondroplasty.

Decision rationale: The California MTUS guidelines state that surgical consideration may be indicated for patients who have 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. MTUS guidelines do not provide specific indications for chondroplasty. The Official Disability Guidelines criteria for chondroplasty include evidence of conservative care (medication or physical therapy), plus joint pain and swelling, plus effusion or crepitus or limited range of motion, plus a chondral defect on MRI. Guideline criteria have not been met. This patient presents with imaging evidence of a complete ACL tear and horizontal tear of the medial meniscus and is pending surgical correction of these tears. There is no current clinical exam or imaging evidence of a chondral defect to support the medical necessity of this request. Therefore, this request is not medically necessary.

Possible Microfracture: 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) - Microfracture.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg: Microfracture surgery (subchondral drilling).

Decision rationale: The California MTUS guidelines do not provide surgical criteria specific to the requested procedure. The Official Disability Guidelines provide specific indications for microfracture surgery that require conservative treatment (medication or physical therapy) for a minimum of 2 months and joint pain and swelling. Objective clinical findings are required to include all the following: small full thickness chondral defect on the weight bearing portion of the medial or lateral femoral condyle, stable knee with intact and fully functional menisci and ligaments, normal knee alignment, normal joint space, and ideal age 45 or younger. Imaging findings demonstrating a chondral defect on the weight bearing portion of the medial or lateral femoral condyle are required. Guideline criteria have not been met. This patient presents with imaging evidence of a complete ACL tear and horizontal tear of the medial meniscus and is pending surgical correction of these tears. There is no current clinical exam or imaging evidence of a small full thickness chondral defect on a weight bearing surface to support the medical necessity of this request. Additionally, there is evidence of instability with functional deficits in the medial meniscus and anterior cruciate ligament. Therefore, this request is not medically necessary.