

<b>Case Number:</b>	CM15-0049942		
<b>Date Assigned:</b>	04/20/2015	<b>Date of Injury:</b>	01/16/2015
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	03/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/16/2015

### 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 50-year-old male who sustained an industrial injury on 1/16/15. The injured worker reported a gradual increase in left knee pain while working on his knees throughout his work shift. He reported trouble walking or straightening his leg at the end of his shift when standing from a kneeling position. The 1/22/15 left knee x-rays were reported as unremarkable. Initial treatment included a knee support, ice/heat, pain medications, anti-inflammatory medication, and modified work. The 2/9/15 left knee MRI impression documented longitudinal horizontal oblique tearing of the posterior horn of the medial meniscus, violating the inferior meniscal surface. There was tricompartmental articular cartilage loss, most pronounced within the patellofemoral compartment. There was minimal deep infrapatellar bursitis and a small popliteal cyst. The 2/17/15 treating physician report cited constant grade 3-6/10 left knee pain. Pain was worse with walking and certain movements. There were no mechanical symptoms. Physical exam documented tenderness over the medial joint line, posteromedial joint line, and medial hamstrings. There was minimal tenderness over the lateral joint line. There was pain medially with valgus stress, and positive medial McMurray's. There was no instability and fair quadriceps strength. The diagnosis included left knee medial meniscus tear, sprain/strain, and chondromalacia. He was advised to do exercises, and use ice and a brace. Authorization was requested for arthroscopy and debridement of left knee meniscectomy, preoperative labs, preoperative chest x-ray, preoperative electrocardiogram, postoperative physical therapy evaluation and 12 physical therapy sessions. He was temporarily totally disabled. The 3/4/15 utilization review non-certified the left knee arthroscopic meniscectomy and debridement and associated surgical requests as surgery for meniscus was not

supported in the setting of osteoarthritis and there was a lack of mechanical findings and documented conservative treatment.

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

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

#### **Left Knee Meniscectomy, Arthroscopy and Debridement: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 116 and 341-342. 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: Meniscectomy.

**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. The Official Disability Guidelines criteria for meniscectomy include conservative care (exercise/physical therapy and medication or activity modification) plus at least two subjective clinical findings (joint pain, swelling, feeling or giving way, or locking, clicking or popping), plus at least two objective clinical findings (positive McMurray's, joint line tenderness, effusion, limited range of motion, crepitus, or locking, clicking, or popping), plus evidence of a meniscal tear on MRI. Guideline criteria have not been met. This injured worker presents with constant left knee pain worse with walking and certain movements. Clinical exam findings are consistent with imaging evidence of a medial meniscus tear. However, there are no mechanical symptoms. Evidence of recent, reasonable and/or comprehensive non-operative treatment protocol trial, including physical therapy and exercise, and failure has not been submitted. Therefore, this request is not medically necessary.

#### **Post Operative Physical Therapy Evaluation and 12 Physical Therapy Sessions: 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.

#### **Preoperative Labs: 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.

**Preoperative Chest X-Ray:** 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.

**Preoperative EKG:** 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.