Case Number:	CM14-0116474		
Date Assigned:	10/23/2014	**Date of Injury:**	07/02/2013
Decision Date:	11/21/2014	**UR Denial Date:**	06/27/2014
Priority:	Standard	**Application Received:**	07/23/2014

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. The expert reviewer is Board Certified in Orthopaedic Surgery and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 male with a date of injury on 7/2/2013. He was employed as an automotive technician at the time of injury. Injury occurred when he slipped on some oil and struck his knee on the sub-frame of a vehicle. Past surgical history was positive for an anterior cruciate ligament (ACL) reconstruction in 2000 and revision ACL reconstruction in 2007. He underwent right knee revision anterior cruciate ligament reconstruction, partial medial meniscectomy, debridement and partial synovectomy on 9/19/13. Conservative treatment included rest, ice/heat, anti-inflammatory medications, physical therapy, anterior cruciate ligament brace, and Synvisc injection on 4/30/14. The 6/11/14 treating physician report cited continued right knee pain with popping, clicking, and locking of the right knee. A physical exam documented a very large and tender plica which was reproducible. The diagnosis included persistent right knee pain with clinical evidence of symptomatic plica and chondromalacia patella. The injured worker had been on medications and completed physical therapy. He had a Synvisc One injection which provided less than 50% relief. The treatment plan recommended arthroscopic excision of plica, and possible chondroplasty, synovectomy, and partial meniscectomy. He was unable to work. The 6/27/14 utilization review denied the right knee arthroscopy and associated requests as there was no evidence of imaging performed since surgery, standing x-rays, diagnostic injection, or appropriate attempts at conservative treatment. The 8/14/14 right knee magnetic resonance (MR) arthrogram impression documented intact ACL graft, anterior tibial translation that could reflect dynamic graft laxity. There was evidence of a prior partial medial meniscectomy with no evidence of a recurrent tear. There was mild medial compartment articular cartilage fissuring with no articular cartilage flap or bone marrow edema. There was medial plica. The 8/26/14 treating physician report cited severe right knee pain with swelling, clicking, locking, tingling, popping, grinding, stiffness, weakness, catching, giving

way, and numbness and tenderness. Symptoms were aggravated by prolonged standing, walking, bending, kneeling, squatting and stair climbing. Symptoms were improved with no activity. Conservative treatment included activity modification, anti-inflammatory medication, ice, heat, and elevation. A physical exam documented moderately antalgic gait, large palpable and very tender plica, mildly positive anterior drawer, and effusion. The treating physician reported persistent right knee pain with clinical evidence of symptomatic plica confirmed on magnetic resonance (MR) arthrogram and mechanical symptoms with clinical evidence of chondromalacia patella. Authorization for right knee arthroscopy was again requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right knee scope excision of plica, partial meniscectomy, chondroplasty, synovectomy: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery, Meniscectomy and Chondroplasty

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, Surgery for impingement syndrome, Chondroplasty and Meniscectomy

Decision rationale: The evidence based guidelines typically 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 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 magnetic resonance imaging (MRI). Neither the Medical Treatment Utilization Schedule (MTUS) nor the Official Disability Guidelines (ODG) provide recommendations for excision of plica. Peer-reviewed literature indicates that symptomatic plica may initially be treated with physiotherapeutic measures and structured exercise regimes, but success rates are generally low. Intra-plical or intra-articular corticosteroid injections may be beneficial if administered early in the disease process. Arthroscopic excision of the entire plica fold becomes indicated in recalcitrant cases and once a plica has undergone irrevocable morphological changes. Guideline criteria have been met. This injured worker presents with significant on-going pain, mechanical symptoms, and functional impairment precluding return to work. There is imaging and clinical exam evidence of medial plica and chondromalacia. Evidence of at least 6 months of a reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Surgery at the meniscal level may be supported upon arthroscopic evaluation. Therefore, this request is medically necessary. There is documentation of imaging evidence consistent with clinical exam. Evidence of at least 6 months of a reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted.

Associated surgical service: post-operative crutches: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338-340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Walking aids (canes, crutches, braces, orthoses, & walkers)

Decision rationale: The evidence based guidelines support the use of crutches for partial weight bearing for injured workers with knee complaints. The Official Disability Guidelines state that disability, pain, and age-related impairments determine the need for a walking aid. Assistive devices can reduce pain and allow for functional mobility. The post-operative use of crutches is consistent with guidelines. Therefore, this request is medically necessary. The associated surgical request has now been found medically necessary.

Associated surgical service: post-operative therapy for right knee, 2 times 4,: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24-25.

Decision rationale: The California Post-Surgical Treatment Guidelines for arthroscopic knee surgery suggest a general course of 12 post-operative visits over 12 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the post-surgical physical medicine period. This is the initial request for post-operative physical therapy and generally consistent with guideline recommendations. Therefore, this request is medically necessary. The associated surgical request has now been found medically necessary.