

<b>Case Number:</b>	CM14-0125212		
<b>Date Assigned:</b>	09/24/2014	<b>Date of Injury:</b>	11/01/2011
<b>Decision Date:</b>	11/19/2014	<b>UR Denial Date:</b>	08/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/07/2014

### 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 Orthopedic Surgery and is licensed to practice in California. 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:

This 53-year-old female janitor sustained an industrial injury on 11/1/11. Injuries were reported to the cervical spine, lumbar spine, bilateral shoulders, right knee and right heel. The mechanism of injury was not documented. Past surgical history was positive for left shoulder arthroscopic rotator cuff repair in October 2012, and right shoulder arthroscopic rotator cuff repair in February 2013. The patient has recently undergone a lumbar epidural steroid injection with benefit. The 7/17/14 treating physician report stated that the patient's right knee was progressively problematic since returning to work. She reported having difficulty with stairs and prolonged weight bearing. Right knee exam documented full range of motion, medial compartment tenderness, positive McMurray's and Apley's tests, and trace effusion. There was positive patellofemoral crepitation and grind test. The 8/11/12 right knee MRI showed grade IV patellofemoral chondromalacia. Updated MRI studies of the left knee were recommended. A request for authorization for diagnostic and operative arthroscopy of the right knee was made, as there were progressively worsening symptoms despite conservative treatment. The 8/4/14 utilization review denied the right knee surgery and associated requests as updated imaging had been recommended but not completed to support the medical necessity of surgery. The 8/23/14 right knee MRI impression documented grade IV chondromalacia patella involving the medial facets (1.5 x 2 cm) and superficial chondral erosion (5 x 4 mm) involving the femoral trochlear groove at midline. There was no significant interval change. There was soft tissue edema at the superior-lateral aspect of Hoffa's fat pad indicating pad impingement. There was intrasubstance degeneration and free edge fraying of the inner posterior horn of the medial meniscus, and a Baker's cyst. Findings documented intrasubstance degeneration of a discoid lateral meniscus without evidence of a tear. The 9/25/14 treating physician appeal request cited continued right knee pain with functional difficulty in prolonged weight bearing activities. Updated MRI

findings revealed grade IV chondromalacia patella and intrasubstance degenerative and free edge fraying of the inner posterior horn of the medial meniscus. Right knee exam confirmed full range of motion with patellofemoral crepitation, trace effusion, and positive McMurray's, apprehension, and patellar grind tests. Diagnostic and operative right knee arthroscopy was recommended for MRI indications of medial meniscal degeneration, as well as lateral meniscal degeneration. The treating physician stated the patient had been continuously symptomatic without any real mitigation with conservative modalities of ice and anti-inflammatories.

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

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

#### **Right knee diagnostic/operative arthroscopic meniscectomy vs. repair possible debridement or chondroplasty: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines -Knee and Leg Chapter regarding Diagnostic Arthroscopy; Indications for surgery; Knee and Leg Chapter regarding meniscectomy; and chondroplasty section.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345, 347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Chondroplasty, Meniscectomy

**Decision rationale:** The California MTUS 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 (ODG) 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. The ODG 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. There is no clear documentation of symptoms, other than simply pain. Records suggest a recent flare-up with return to work. There was no interval change in imaging findings of chondromalacia patella. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

**Assistant Surgeon:** 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 Clearance: Labs (CBC, CMP, PT, PTT, hep panel, HIV panel, UA):**

**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 Clearance: 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.

**Preoperative Clearance: Chest XRay: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACR Appropriateness Criteria® routine admission and preoperative chest radiography. Reston (VA): American College of Radiology (ACR); 2011. 6 p.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Knee Brace: 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.

**Post operative Physical Therapy two (2) time a week for six (6) weeks: 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.