

Case Number:	CM14-0139802		
Date Assigned:	09/08/2014	Date of Injury:	03/03/2012
Decision Date:	10/21/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	08/28/2014

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 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 41-year-old male who reported an injury on 03/03/2012 due to an unknown mechanism. Diagnoses were internal derangement of the right knee, resolved radiculopathy. Past treatments were medications, and physical therapy from 07/15/2014 to 08/12/2014 of 12 sessions. Diagnostic studies were MRI of the right knee that revealed displaced meniscal tear affecting the posterior horn of the medial meniscus, for which a follow-up MR arthrogram of the knee is suggested for further evaluation. High grade chondromalacia patella with a small retropatellar joint effusion. Surgical history was status post lumbar laminectomy. Physical examination dated 07/31/2014 revealed complaints from the injured worker of significant popping and sensation of knee giving out in the right knee. Physical examination on 08/28/2014 revealed complaints of the right knee gives out on him. Examination of the right knee revealed right knee flexion was to 110 degrees, extension was to -5 degrees. There was pain toward terminal range of motion of the right knee. There was some joint line tenderness in the right knee. There was some positive Apley's. Motor examination of the right knee was 5/5. Deep tendon reflexes for the right knee patellar was a 2, Achilles was 2. Medications were not reported. Treatment plan was for right knee arthroscopy. The rationale was "I had a lengthy discussion with the patient regarding the findings. The patient does have moderate discomfort in pain in the knee. His knee gives out on him. He had locking sensation in the knee. He was unable to walk for a prolonged period of time. He was quite happy with the improvement he had by getting his back surgery." The Request for Authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right knee arthroscopy: Upheld

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

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 decision for right knee arthroscopy is not medically necessary. The California ACOEM states for arthroscopic partial meniscectomy usually has a high success rate for cases in which there is clear evidence of a meniscus tear/symptoms other than simply pain (locking, popping, giving away, recurrent effusion), clear signs of a bucket handle tear on examination (tenderness over the suspected tear but not over the entire joint line, and perhaps lack of full passive flexion), and consistent findings on MRI. However, patients suspected of having meniscal tears, but without progressive or severe activity limitation, can be encouraged to live with symptoms to retain the productive effect of the meniscus. The Official Disability Guidelines states the criteria for meniscectomy or meniscus repair (suggest 2 symptoms and 2 signs to avoid scopes with lower yield, e.g. pain without other symptoms, posterior joint line tenderness that could just signify arthritis, MRI with degenerative tear that is often false positive). Physiologically younger and more active patients with traumatic injuries and mechanical symptoms (locking, blocking, and catching) should undergo arthroscopy without physical therapy. Conservative care is not required for locked/blocked knee. Exercise/physical therapy (supervised PT and/or home rehab exercises, if compliance is adequate), and medications, or activity modification (crutches and/or immobilizer). There should also be subjective clinical findings of at least 2 of the following joint pain, swelling, and feeling of give away, locking, clicking, or popping. There should be objective clinical findings of at least 2 of the following, positive McMurray's sign, joint line tenderness, and effusion, limited range of motion, locking, clicking, or popping, crepitus. Imaging clinical findings (not required for locked/blocked knee. (meniscal tear on MRI) order MRI only after above criteria are met). The injured worker had complaints of joint pain, and locking, and feeling of giving way. Objective clinical findings were joint line tenderness, and limited range of motion. On the injured worker's eleventh visit of physical therapy dated 08/12/2014, it was revealed that the injured worker had right knee pain that persisted and was worse when doing home exercises. Also reported was knee remains unstable and painful and need cane for safety and stability as the injured worker feels his knee will give way. The injured worker had 12 visits of physical therapy because he was status post lumbar laminectomy. It was not reported on the physical therapy notes that the injured worker was having physical therapy for the right knee. The plan on the physical therapy note stated the injured worker needs additional strengthening for the right leg. The clinical documentation submitted for review does not justify that conservative care has been fully rendered. Therefore, this request is not medically necessary.