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| Case Number: | CM14-0160449 | | |
| Date Assigned: | 10/06/2014 | Date of Injury: | 05/01/2011 |
| Decision Date: | 11/06/2014 | UR Denial Date: | 09/18/2014 |
| Priority: | Standard | Application Received: | 09/30/2014 |

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 44 year old female with a date of injury on 5/1/2011. The mechanism of injury was not documented. Her past surgical history was positive for right shoulder surgery on 8/7/12 and a microdiscectomy at L5/S1 on 8/13/13. Post-operative rehab was documented for the shoulder and back. The injured worker experienced an acute flare-up of low back and lower extremity radicular symptoms in December. Magnetic resonance imaging findings were positive for a left L5/S1 with probable mass effect on the left L5 nerve root. A request for left L5/S1 laminotomy with a repeat lumbar microdiscectomy was submitted. Recent conservative treatment had included over-the-counter anti-inflammatory medications and 8 sessions of physical therapy for the low back as well as left leg complaints. The 8/1/14 right knee magnetic resonance imaging impression documented early degenerative arthritis, marrow reconversion in the distal femur, small knee joint effusion, and Wiberg type 2 patella showing lateral subluxation. Findings documented the medial and lateral menisci were normal in configuration and signal intensity. The 9/11/14 orthopedic report cited right knee pain and locking in addition to the lumbar disc pain. The right knee physical exam documented positive McMurray's test for probable medial meniscus tear and positive apprehension sign for chondromalacia. The diagnosis was right knee derangement. Authorization was requested for right knee arthroscopy. The 9/18/14 utilization review denied the request for right knee arthroscopy as there was no documentation of any recent conservative treatment to the knee and no clear imaging evidence of a surgical lesion.

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 Page(s): 116, 341-342, 344. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee, Indications for Surgery

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 Official Disability Guidelines (ODG) Knee and Leg, Chondroplasty

Decision rationale: The evidence based guidelines state that surgical consideration may be indicated for injured workers 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. 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 the magnetic resonance imaging scan. The Official Disability Guidelines criteria for chondroplasty include evidence of conservative care, plus joint pain and swelling, plus effusion or crepitus or limited range of motion, plus a chondral defect on the magnetic resonance imaging scan. Guideline criteria have not been met. Clinical exam evidence is limited and fails to fully meet guideline criteria for meniscectomy or chondroplasty. There is no documentation of functional limitation specific to the right knee. There is no imaging evidence of a meniscal tear or chondral lesion. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the right knee and failure has not been submitted. Therefore, this request is not medically necessary.