

<b>Case Number:</b>	CM15-0016201		
<b>Date Assigned:</b>	02/04/2015	<b>Date of Injury:</b>	06/04/2014
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	12/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2015

### 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: California  
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 58 year old female who sustained a work related injury June 4, 2014, to the right knee. Diagnosis documented as knee contusion and she was initially treated with conservative measures and physical therapy. According to a physician's progress report dated November 6, 2014, the injured worker presented for follow-up with intense right knee pain, rated 10/10. Physical examination reveals trace anterior swelling; right knee flexion and extension are full but painful; gait is antalgic on the right. Diagnosis is documented as right knee pain, likely patellofemoral syndrome. MRI of the right knee 7/8/14 demonstrates a free edge fraying of the medial meniscus without tearing. No chondral defect is noted. Treatment included request for aqua therapy, acupuncture, TENS unit, and medications. Work status; remain off work until next follow-up. There are no further current progress reports in the current medical record. According to utilization review dated December 30, 2014, the request for Right Knee Arthroscopy Synovectomy and Menisectomy is non-certified, citing MTUS ACOEM Guidelines, Knee Complaints. The request for Post-operative Physical Therapy 2 x 6 is non-certified, citing MTUS Post-surgical Treatment Guidelines. The request for Cold Therapy Unit-7 day rental is non-certified, citing ODG Guidelines Knee Chapter, Cryotherapies.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right knee arthroscopy synovectomy meniscectomy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg, Meniscectomy

**Decision rationale:** CAMTUS/ACOEM Chapter 13 Knee Complaints, pages 344-345, states regarding meniscus tears, "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 way, recurrent effusion). According to ODG Knee and Leg section, Meniscectomy section, states indications for arthroscopy and meniscectomy include attempt at physical therapy and subjective clinical findings, which correlate with objective examination and MRI. In this case the exam notes from 11/6/14 do not demonstrate evidence of adequate course of physical therapy or other conservative measures. In addition there is lack of evidence in the cited records of a meniscus tear from the MRI of 7/8/14. Therefore the determination is for non-certification.

**Post operative physical therapy twice a week for six weeks:** Upheld

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

**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.

**Cold therapy unit 7-day rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299, 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter

**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.