

<b>Case Number:</b>	CM15-0178765		
<b>Date Assigned:</b>	09/21/2015	<b>Date of Injury:</b>	09/12/2014
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	08/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2015

### 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 37 year old male, who sustained an industrial injury on 9-12-14. The injured worker has complaints of left knee pain with joint pain and tenderness. The documentation noted on 8-18-15 that there is maximal tenderness at the medial joint line on the left knee and there is mild swelling. The left knee range of motion for flexion active was 135 degrees and extension active was 0 degrees. MRI of the left knee from 6/15/15 demonstrates no evidence of meniscal tear and no defect of the patellar or trochlear articular cartilage. Magnetic resonance imaging (MRI) of the lumbar spine on 7-6-15 showed mild canal stenosis at L3-4 and L5-S1 (sacroiliac); there is a 7 millimeter grade 1-11 anterolisthesis of L5 on S1 (sacroiliac) with bilateral defects of the pars interarticularis; there is central and paracentral annular tearing at L5-S1 (sacroiliac) and correlate with bilateral S1 (sacroiliac) radiculopathy. The diagnoses have included chondromalacia and medial meniscal derangement. Treatment to date has included corticosteroid injection of the left side. The original utilization review (8-25-15) non-certified the request for one left medial meniscectomy knee arthroscopy; one left chondral shave knee arthroscopy; one assistant surgeon and 12 sessions of post op physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One left medial meniscectomy knee arthroscopy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 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 MRI from 6/15/15 does not demonstrate evidence of meniscal pathology. Therefore the determination is for not medically necessary.

**One left chondral shave knee arthroscopy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation knee and leg, chondroplasty.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of chondroplasty. According to the ODG Knee and Leg regarding chondroplasty, criteria include conservative care, subjective clinical findings of joint pain and swelling plus objective clinical findings of effusion or crepitus plus limited range of motion plus chondral defect on MRI. In this case the MRI from 6/15/15 does not demonstrate a clear chondral defect on MRI nor does the exam note demonstrate objective findings consistent with a symptomatic chondral lesion. Therefore the determination is for not medically necessary.

**Associated surgical services: One assistant surgeon:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare & Medicaid Services.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.aaos.org/about/papers/position/1120.asp>.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**12 Sessions of post op physical therapy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment 2009, Section(s): Knee.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.