MAXIMUS Federal Services

Case Number:	CM15-0063862		
Date Assigned:	04/09/2015	Date of Injury:	02/24/2011
Decision Date:	05/14/2015	UR Denial Date:	03/13/2015
Priority:	Standard	Application Received:	04/03/2015

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: Illinois, California, Texas
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 55 year old male who sustained an industrial injury on 02/24/11. Injury occurred when he hit his right leg on a towing hitch. The impact caused him to lock his right knee and the momentum made him fall on his left leg/knee. Past surgical history was positive for left knee arthroscopy on 10/24/13, and right total knee replacement on 8/29/14. The 2/9/15 treating physician report cited multiple areas of pain complaint in the bilateral upper and lower extremities, lumbosacral spine, and buttocks/sacroiliac regions, with numbness and tingling occurring 90% of the time. Pain ranged from grade 5-8/10. Left lower extremity complaints included anterior and posterior knee, posterior leg, calf, ankle, and foot pain. He reported he felt better with pain medications, home exercise, and physical therapy. Physical exam documented right knee medial and lateral joint line tenderness with 0-130 degrees range of motion. There was 4/5 right knee flexion/extension weakness, all other lower extremity motor testing documented 5/5 strength. Deep tendon reflexes and sensation were intact. The diagnosis was bilateral knee osteoarthritis, degenerative joint disease, and bilateral knee complex medial meniscus tear. The treatment plan recommended left knee arthroscopy, meniscus surgery, chondroplasty, and synovial debridement and continued physical therapy for the left knee 2x6. The 3/17/15 utilization review non-certified the request for left knee arthroscopy, meniscus surgery, chondroplasty, and synovial debridement. The rationale for non-certification indicated that there was no clear evidence of internal derangement worthy of surgery and no imaging or weight bearing x-rays.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left knee arthroscopy/meniscus S/chondroplasty and synovial debridement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-344, Chronic Pain Treatment Guidelines Page(s): 99.

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: Chondroplasty.

Decision rationale: The California MTUS guidelines state that surgical consideration may be indicated for patients 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. 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 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. The injured worker complained of generalized left lower extremity pain including the anterior/posterior knee, posterior leg, calf, ankle, and foot pain. There were no mechanical symptoms documented. Left lower extremity muscle strength, deep tendon reflexes, and sensation were intact and within normal limits. There were no clinical findings consistent with meniscal or chondral pathology documented. There was no documentation of imaging or radiographic findings to support the medically necessary of this request. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the left knee and failure has not been submitted. Therefore, this request is not medically necessary.