

<b>Case Number:</b>	CM15-0073605		
<b>Date Assigned:</b>	04/23/2015	<b>Date of Injury:</b>	11/09/2012
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	03/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/17/2015

### 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 42-year-old male who sustained an industrial injury on 11/09/12. Injury occurred when his left ankle got caught up in a hose and he was dragged 25 feet behind a vehicle. He sustained a comminuted fracture of the left wrist and underwent open reduction and internal fixation left distal radius fracture. He underwent knee arthroscopic medial meniscus debridement in April 2013, left exploration of the ulnar nerve on 9/4/14, and a left hip arthroscopic labral repair and femoral neck resection with chondroplasty of the acetabulum on 2/11/15. The 2/2/15 left knee MR arthrogram demonstrated meniscal remnant was mild to moderately diminutive in size consistent with prior partial meniscal resection with no enhancing tear. The lateral meniscus revealed minimal fibrillation along the free edge of the mid-zone. There was chronic moderate to high-grade sprain of the medial collateral ligament with exuberant ossification proximally consistent with advanced Pelligrini-Stieda disease. There were mild to moderate patellofemoral joint chondromalacic changes medially. The 3/18/15 treating physician report relative to exam date 3/6/15 cited constant left knee pain with associated numbness and tingling in the left leg. The knee felt like it would hyperextend back when walking up stairs or inclines. It did not lock. He was unable to kneel or squat. He had difficulty getting dressed, putting on shoes and socks, doing housework, driving, and sleeping through the night. The injured worker had a large body habitus and there was global ligamentous laxity. He was grossly neurologically intact in the left lower extremity. Left knee exam documented moderate medial joint line and popliteal fossa tenderness. There was trace effusion with a very palpable fullness medially. Range of motion was 0-120 degrees with no pain or crepitus. Muscle strength

and patellar tracking were normal. There was a positive valgus stress test and positive McMurray's. X-rays were taken and revealed significant ectopic ossification consistent with chronic medial collateral ligament avulsion and what appeared to be a loose body within the central notch. The diagnosis was chronic medial collateral ligament disruption with medial meniscus tear. The treatment plan recommended left knee arthroscopic medial meniscectomy and open osteophyte removal of medial distal femur. Authorization was requested for left knee arthroscopy and open osteophyte removal with an assistant surgeon, post-operative physical therapy, crutches, post-operative anti-embolism stockings, and a 2-week post-operative rental of a TENS unit. The 3/23/15 utilization review non-certified the request for left knee arthroscopy and open osteophyte removal and associated surgical requests as there was no evidence of a medial meniscus tear and no evidence of failure of conservative treatment methods for function impairment.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Left knee arthroscopy, meniscus repair, open osteophyte removal: Upheld**

**Claims Administrator 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 Chapter.

**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: Arthroscopic surgery for osteoarthritis.

**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 state that arthroscopic surgery in the presence of significant knee OA should only rarely be considered for major, definite and new mechanical locking/catching (i.e., large loose body) after failure of non-operative treatment. Guideline criteria have not been met. This injured worker presents with constant left knee pain and instability. Clinical exam findings included findings of ligament laxity, effusion, and positive McMurray's. Imaging did not demonstrate a clear medial meniscus tear. There was imaging evidence of a high-grade medial collateral ligament sprain with exuberant ossification consistent with Pellegrini-Steida disease. However, detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.

**Assistant surgeon: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

**Post-operative physical therapy for the left knee, three times weekly for six weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

**Crutches:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Walking aids (canes, crutches, braces, orthoses, & walkers).

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Anti-embolism stockings:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg: Compression garments.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.