

<b>Case Number:</b>	CM14-0151646		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	06/11/2014
<b>Decision Date:</b>	11/05/2014	<b>UR Denial Date:</b>	08/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2014

### 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, has a subspecialty in Sports Medicine, and is licensed to practice in California. 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 54-year-old male who reported an injury on 06/11/2014 due to lifting a water heater. Diagnoses were lumbar degenerative disc disease, lumbar facet arthropathy and lumbar radiculitis. Physical examination on 06/26/2014 revealed complaints of low back pain. The pain was rated anywhere from a 5/10 to a 10/10. The pain reported to radiate into both lower extremities, left more than right, down to the calf. It was reported that the pain decreased with rest and medications. Medications were metformin, simvastatin, lisinopril, amlodipine, hydrochlorothiazide, tramadol and baclofen. MRI of the lumbar spine revealed mild to moderate degenerative disc disease at the L3-4, L4-5 and L5-S1. MRI of the left knee revealed medial meniscus posterior horn and body complex tears, lateral meniscus posterior horn radial tear with probable displaced fragment seen just above the lateral tibial spine, complex long standing rupture of the ACL, posterior cruciate ligament mucoid degeneration and likely associated high grade sprains, and scattered areas of tricompartmental joint space chondromalacia. Examination revealed flexion of the lumbar spine was to 40 degrees, extension was to 25 degrees, and lateral flexion was to the right 25 degrees and to the left 20 degrees. Straight leg raise test was negative in the supine and sitting position. Positive facet loading on extension at L5-S1, L4-5 on the left side. There was no focal sensory or motor deficits in the lower extremities. The treatment plan was for physical therapy or chiropractic therapy. The rationale and Request for Authorization were not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Arthroscopic Knee Surgery Left Knee: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints  
Page(s): 343-345.

**Decision rationale:** The request for arthroscopic knee surgery left knee is not medically necessary. The California ACOEM states referral for surgical consultation may be indicated for patients who have activity limitation for more than 1 month, and failure of exercise programs to increase range of motion and strength of the musculature around the knee. Earlier, emergency consultation is reserved for patients who may require drainage of acute effusions or hematomas. Referral for early repair of ligament or meniscus tears is still a matter for study because many patients can have satisfactory results with physical rehabilitation and avoid surgical risk. Anterior cruciate ligament reconstruction generally is warranted only for patients who have significant symptoms of instability caused by ACL incompetence. Anterior cruciate ligament tears often are followed by an immediate effusion of the knee. A history of frequent giving way episodes, or falls during activities that involve knee rotation, is consistent with the condition. A physical examination in an acute setting may be unrevealing because of the effusion and immobilization of the knee. In addition, the physical examination may reveal clear signs of instability as shown by positive Lachman's, drawer and pivot shift tests. It is important to confirm the clinical findings with MRI evidence of a complete tear in the ligament. Especially in cases involving partial ACL tears, substantial improvement in symptoms may occur with rehabilitation alone. Incomplete tears, consideration should be given to the patient's age, normal activity level, and the degree of knee instability caused by the tear. Surgical reconstruction of the ACL may provide substantial benefit to active patients, especially those under 50 years old. For the patient whose work or life does not require significant loading of the knee and other stressful conditions, ACL repair may not be necessary. It was not reported that the injured worker has had any type of physical therapy or chiropractic sessions. The medical guidelines suggest conservative care such as physical therapy be implemented first. The injured worker did not report any type of instability of the left knee. The physical examination on the injured worker dated 06/24/2014 did not have an examination of the left knee reported. It was reported that the injured worker had a normal gait pattern. The clinical information submitted for review does not provide evidence to justify arthroscopic knee surgery left knee. Therefore, this request is not medically necessary.