MAXIMUS Federal Services

Case Number:	CM13-0020238		
Date Assigned:	01/03/2014	Date of Injury:	10/18/2011
Decision Date:	03/18/2014	UR Denial Date:	08/21/2013
Priority:	Standard	Application Received:	09/04/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, 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 physician 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 patient is a 29-year-old male who sustained a work-related injury on 10/18/11. He has undergone two anterior cruciate ligament (ACL) reconstructions. Subjective complaints include feeling like the knee is pushed back into hyperextension, some irritation by a prominence about the distal medial tibial near the tibial tunnel, and plateau motion since getting out of post-op brace. Objective findings include 1+ Lachman, positive anterior drawer, terminal extension that is about 1-2 degrees short of full extension, small amount of patellofemoral crepitus with flexion, and mild tenderness to palpation over the tibial incision. An MRI of the left knee on 4/18/13 revealed status post revision of an ACL graft, status post partial lateral meniscectomy, demonstration of a radial tear of the medial meniscus posterior horn/root junction; and patellar tendon scarring related to prior anterior cruciate ligament graft harvest. There was no complicating process identified and the tibial tunnel is posterior to Blumensaat's line. There was fibrosis along the dorsal margin of Hoffa's fat. Current diagnoses include status post revision left knee ACL reconstruction and left knee postoperative contracture, and treatment to date has been knee bracing, physical therapy, and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

left knee arthroscopy with debridement, lysis of adhesions, and possible bony notchplasty: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation www.wheelessonline.com/ortho/arthrofibrosis_from_acl_injuries.com.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation www.wheelessonline.com/ortho/arthrofibrosis_from_acl_injuries.com; and www.lifebridgehealth.org/RIAO/Knee.aspx

Decision rationale: The MTUS/ACOEM guidelines state that knee surgery may be recommended with documentation of activity limitations for more than one month and failure of exercise programs to increase the range of motion and strength of the musculature around the knee. Arthroscopic interventions for lysis of adhesions should be limited to local fibrosis and therapy resistant cases. Within the medical information available for review, there is documentation of diagnoses of status post revision left knee ACL reconstruction and left knee postoperative contracture. In addition, there is documentation of feeling like the knee is pushed back into some hyperextension, some irritation by a prominence about the distal medial tibial near the tibial tunnel, and plateau motion since getting out of post-op brace, an MRI identifying fibrosis along the dorsal margin of Hoffa's fat, and a history of failed conservative treatment, including knee bracing, physical therapy, and medications. However, given documentation of terminal extension that is about 1-2 degrees short of full extension, there is no documentation of significant functional deficits for which the requested procedure would be indicated. Therefore, based on guidelines and a review of the evidence, the request is noncertified.