

Case Number:	CM14-0001414		
Date Assigned:	01/22/2014	Date of Injury:	04/30/2013
Decision Date:	12/02/2014	UR Denial Date:	12/11/2013
Priority:	Standard	Application Received:	01/03/2014

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 and is licensed to practice in Texas. 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 41 year old female with a date of injury on 4/30/2013. Injury occurred relative to a fall while working as a waitress. The injured worker sustained a patellar fracture. She underwent partial distal pole patellectomy right knee inferior pole patellar fracture with repair of the patellar tendon on 5/6/13. Extensive physical therapy was requested following surgery. The 10/30/13 right knee magnetic resonance imaging scan impression documented subacute, intra-articular fracture of the lateral patellar facet, with postsurgical change and inferolateral articular cartilage defect measuring up to 5.5 mm. There was tendinosis and postsurgical change of the distal quadriceps and patellar tendons, with patella baja. Tibial tuberosity-trochlear distance was within normal limits and menisci were intact. The 11/7/13 treating physician progress report indicated that the worker had not notably improved in range of motion with therapy. She used a cane to assist with ambulation especially with stairs and inclines. She reported swelling if she walked too far, otherwise there was no significant pain with ambulation. Physical exam documented range of motion 5-45 degrees with a hard end-point to further flexion and no significant pain. There was obvious arthrofibrosis of the parapatellar region and patella baja. Body mass index was documented as 28.34. The diagnosis included arthrofibrosis right knee with patella baja, limited knee flexion secondary to arthrofibrosis right patellofemoral joint, and articular cartilage injury inferior lateral patella. The treating physician opined that the injured worker had a difficult problem that would likely require multiple surgeries to obtain optimal outcome. Initial recommendation was for right knee arthroscopic lysis of adhesions, medial and lateral retinacular release, and resection of scar patella fat pad to help with range of motion and patella baja. The 12/11/13 Utilization Review denied the request for right knee surgery as physical exam documentation did not meet guideline criteria relative to Q angle or lateral tracking of the patella, patellofemoral instability, patellar subluxation, or

discussion of patella fat pad pathology, and there was limited documentation relative to physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Knee Arthroscopic Lysis of Adhesions, Medial and Lateral Retinacular Release and Resection of Scar Patella Fat Pad: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. 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, 347. Decision based on Non-MTUS Citation Magit D, Wolff A, Sutton K, Medvecky MJ. Arthrofibrosis of the knee. J Am Acad Orthop Surg. 2007 Nov;15(11):682-9; and Drago JL, Johnson C, McConnell J. Evaluation and treatment of disorders of the infrapatellar fat pad. Sports Med. 2012 Jan 1;42(1):51-67

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that surgical consideration may be indicated for workers 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. The Official Disability Guidelines recommend patella stabilization, in the form of lateral retinacular release, when criteria are met. Indications include physical therapy or medications, and pain with sitting or patellar/femoral movement or recurrent dislocations. Clinical exam findings should include lateral tracking of the patella, recurrent effusion, patellar apprehension, synovitis with or without crepitus, and Q angle greater than 15 degrees. Imaging findings of abnormal patellar tilt are required. Peer reviewed literature supports the use of manipulation under anesthesia in conjunction with arthroscopic lysis of adhesions as a reliable treatment option for arthrofibrosis of the knee. Literature indicates that infrapatellar fat pad pathology refractory to physical therapy can be approached through a variety of operative treatments. Arthroscopic partial resection for infrapatellar fat pad impingement and Hoffa's disease has showed favorable results. Guideline criteria have been met for surgical treatment of arthrofibrosis. This injured worker presents with significant post-operative loss of range of motion with a hard end feel and despite extensive physical therapy treatment. Therefore, this request is medically necessary. Guideline criteria have been met for surgical treatment of arthrofibrosis. This injured worker presents with significant post-operative loss of range of motion with a hard end feel and despite extensive physical therapy treatment.

Pre-Operative Labs (CBC, Chem 7, UA and EKG): Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic (Acute & Chronic) Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38

Decision rationale: The Chronic Pain Medical Treatment Guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, worker interview, physical examination, and type and invasiveness of the planned procedure. Guidelines state that an electrocardiogram may be indicated for workers with known cardiovascular risk factors or for workers with risk factors identified in the course of a pre-anesthesia evaluation. Middle-aged overweight females have known occult increased medical/cardiac risk factors. Guideline criteria have been met based on the injured worker's age, magnitude of surgical procedure, recumbent position, fluid exchange and the risks of undergoing anesthesia. As the surgery has now been found to be medically necessary, this request is medically necessary.

Home Continuous Passive Motion (CPM) Machine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter

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, Continuous passive motion (CPM)

Decision rationale: The Chronic Pain Medical Treatment Guidelines do not provide recommendations for this device following knee arthroscopy. The Official Disability Guidelines state that the use of a continuous passive motion device may be considered medically necessary in the acute hospital setting for 4 to 10 days (no more than 21 days) following total knee replacement, anterior cruciate ligament reconstruction, or open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint. Home use is supported up to 17 days while the worker at risk of a stiff knee is immobile or unable to bear weight following a primary or revision total knee arthroplasty. There is no guideline support for the routine or prophylactic use of a continuous passive motion unit following knee arthroscopy. Although continuous passive motion could be reasonable given the significant loss of pre-operative range of motion, there is no specific duration of use to establish medical necessity. Therefore, this request is not medically necessary.