

<b>Case Number:</b>	CM14-0011937		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	11/14/2013
<b>Decision Date:</b>	06/27/2014	<b>UR Denial Date:</b>	01/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/29/2014

### 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 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:

This 36-year-old male [REDACTED] sustained an industrial left knee injury on 11/14/13. Injury occurred when he lost his footing while running down a flight of stairs, and felt a pop in his left knee. The 11/21/13 left knee MRI impression documented an anterior cruciate ligament tear, likely a high grade partial tear with intact lateral fibers. There was a bone contusion noted in the posterior aspect of the lateral tibial plateau, and moderate sized joint effusion. The medial and lateral menisci were normal in morphology and signal characteristics. The 12/2/13 surgical consult documented persistent left knee pain, swelling, stiffness, and giving episodes. Left knee exam findings documented normal range of motion, positive effusion, positive Lachman's, and positive pivot shift. The treatment plan recommended arthroscopic anterior cruciate ligament reconstruction. The 12/19/13 utilization review denied the surgical request based on an absence of conservative treatment failure. The 1/13/14 treating physician report cited subjective complaints of continued pain, instability, weakness, and stiffness. Physical exam documented 2+ Lachman, 2+ anterior drawer, 2+ pivot shift, and no varus, valgus or posterior patholaxity. The diagnosis was left knee sprain/strain twisting injury, with MRI confirmed anterior cruciate ligament tear. Failure of conservative treatment was documented, including physical therapy, home exercise, activity modification, and anti-inflammatory medication. Symptoms had progressed since the date of injury. The treatment plan recommended surgery with pre-operative and post-operative services. The 1/28/14 utilization review denied the request for surgery and associated items/services as this injury is only 2 months old and there is limited documentation that conservative measures had been exhausted and failed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DIAGNOSTIC/OPERATIVE LEFT KNEE ARTHROSCOPY, POSSIBLE ARTHROSCOPIC MENISCECTOMY VS REPAIR ANTERIOR CRUCIATE LIGAMENT RECONSTRUCTION WITH PATELLA TENDON AUTOGRAFT:**

Overtured

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Knee and Leg Procedure.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Anterior cruciate ligament (ACL) reconstruction, Meniscectomy.

**Decision rationale:** Under consideration is a request for diagnostic/operative left knee arthroscopy, possible arthroscopic meniscectomy vs. repair, anterior cruciate ligament (ACL) reconstruction with patella tendon autograft. The California MTUS ACOEM guidelines state that anterior cruciate ligament reconstruction generally is warranted only for patients who have significant symptoms of instability caused by ACL incompetence. In cases involving partial tears, substantial improvement in symptoms may occur with rehabilitation alone. In complete 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. Guidelines state that arthroscopic partial meniscectomy usually has a high success rate for cases with clear evidence of a meniscus tear. Evidence includes symptoms other than simply pain (locking, popping, giving way, recurrent effusion), objective findings (tenderness over the suspected tear but not over the entire joint line, and perhaps lack of full passive flexion), and consistent findings on MRI. Guideline criteria have been met. This patient presents with MRI findings of a high grade ACL tear. Signs and symptoms are positive for an ACL tear. Despite the clinical and imaging findings, there is often associated contribution of the symptoms due to notable (and later intra-operatively confirmed associated) meniscal pathology. Reasonable non-operative treatment had been tried and failed in this 36 year old active patient. Therefore, this request for diagnostic/operative left knee arthroscopy, possible arthroscopic meniscectomy vs. repair, anterior cruciate ligament (ACL) reconstruction with patella tendon autograft is medically necessary.

**ASSISTANT SURGEON:** Overtured

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopaedic Surgeon Position Statement Reimbursement of the First Assistant Surgery in Orthopaedics.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee Schedule.

**Decision rationale:** As the requested left knee surgery is medically necessary, and complex, the request for assistant surgeon is also medically necessary.

**PRE-OPERATIVE KT-1000 ISOMETRIC TEST: 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, KT 1000 Arthrometer.

**Decision rationale:** The request for pre-operative KT1000 isometric test is not medically necessary as it would not result in any significant clinical treatment course alteration and/or outcome difference.

**COLD THERAPY UNIT TIMES 14 DAYS RENTAL: 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.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Continuous flow cryotherapy.

**Decision rationale:** Guidelines support up to 7 days utilization only however also reflect the lack of improved outcomes as compared to typically readily available ice packs. Therefore; the request for cold therapy unit x14 day rental is not medically necessary.

**POST OPERATIVE PHYSICAL THERAPY 3 TIMES 6: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25.

**Decision rationale:** ODG criteria:"Post-surgical (ACL repair): 24 visits over 16 weeks." The requested left knee surgery is medically necessary, the request for post-operative physical therapy 3x6 is also medically necessary.

**KNEE CPM UNIT TIMES 30 DAY RENTAL: 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) -TWC Knee and Leg Procedure Summary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Continuous passive motion (CPM).

**Decision rationale:** Guidelines support no more than 21 days CPM utilization (although long term outcome differences have not been evidenced in overall outcomes.) Therefore, the request for knee CPM unit x 30 day rental is not medically necessary.

**E-STIM TIMES 14 DAYS-RENTAL:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114, 116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 116-117.

**Decision rationale:** As long term literature studies have not supported overall efficacy in such a clinical setting(as per ODG criteria); the request for E-stim x 14 days rental is not medically necessary.

**T-ROM BRACE:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339-340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Knee brace.

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

**Decision rationale:** As the requested left knee surgery is medically necessary, the request for T-ROM brace is also medically necessary for post-op. pain and repair control.

**CRUTCHES:** 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) -TWC Knee and Leg Procedure Summary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Crutches, Walking aids.

**Decision rationale:** As the requested left knee surgery is medically necessary, the request for crutches is also medically necessary for gait assist, pain and repair control.

**PRE-OPERATIVE MEDICAL CLEARANCE:** 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 Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation.

**Decision rationale:** As the requested left knee surgery is medically necessary, the request for pre-operative medical clearance is also medically necessary to assess risk factors.