

Case Number:	CM15-0217467		
Date Assigned:	11/09/2015	Date of Injury:	10/31/2014
Decision Date:	12/21/2015	UR Denial Date:	10/30/2015
Priority:	Standard	Application Received:	11/04/2015

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:

This injured worker is a 40-year-old male who sustained an industrial injury on 10/31/14. Injury occurred when he slipped and fell, landing on his knee. He was diagnosed with a quadriceps tendon rupture and underwent a quadriceps tendon repair on 11/14/14. He completed 33 post-operative physical therapy visits as of 7/15/15. Records documented on-going left knee pain, swelling and mechanical symptoms worse with prolonged standing and walking, and with physical therapy. Conservative treatment included medications, activity modification, cane/crutch, physical therapy, and home exercise. The 10/15/15 left knee MRI impression documented a longitudinal horizontal tear of the posterior horn of the medial meniscus. A previous surgical repair of the extensor mechanism was noted with improved appearance of the distal quadriceps and proximal patellar tendons compared to the May 2015 MRI. There was tendon thickening but there was maturation of the signal from intermediate to low signal intensity throughout the quadriceps and throughout roughly 50% of the proximal patellar tendon. There was partial thickness cartilage fissuring of the lateral tibia and femur, not significantly changed. There were changes consistent with bone demineralization. The 10/15/15 left knee MRI study to evaluate patellar tracking documented slight lateral patellar tilt and overhang at full extension. There was improvement with increasing flexion and muscular activation. The 10/22/15 treating physician report cited persistent left knee pain and swelling, intermittent buckling, and pop/grind with extension. He was doing physical therapy and home exercise program. Left knee exam documented swelling, positive lateral patella tracking, mildly positive patellofemoral grind, and guarded range of motion from 0-125 degrees. There was quadriceps

atrophy, and significantly positive McMurray's test. The injured worker was very tender over the medial joint line. In extension, there was a positive lateral posture of the patella. Q-angle was within normal limits. Based on symptoms, exam, and imaging, additional surgery was recommended. Authorization was requested for left knee arthroscopy, partial medial meniscectomy, and reconstruction of the medial patellofemoral ligament using tendon allograft with suture anchors, and 12 post-op physical therapy visits. The 10/30/15 utilization review modified the request for left knee arthroscopy, partial medial meniscectomy, and reconstruction of the medial patellofemoral ligament using tendon allograft with suture anchors, to left knee arthroscopic partial medial meniscectomy as there was no imaging evidence of a full tear or significant pathology of the patellofemoral ligament to warrant surgery, and no clear rationale to support reconstruction of the patellofemoral ligament. The request for 12 post-op physical therapy visits was modified to 6 visits consistent with Post-Surgical Treatment Guidelines for initial post-operative treatment for meniscectomy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Knee Arthroscopy Partial Medial Meniscectomy Reconstruction of the Medial Patella Femoral Ligament Using Tendon Allograft with Suture Anchors: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

Decision based on Non-MTUS Citation

http://www.wheelsonline.com/ortho/medial_patellofemoral_ligament.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg: Meniscectomy; Patellar tendon repair.

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 criteria for meniscectomy include conservative care (exercise/physical therapy and medication or activity modification) plus at least two subjective clinical findings (joint pain, swelling, feeling or giving way, or locking, clicking or popping), plus at least two objective clinical findings (positive McMurray's, joint line tenderness, effusion, limited range of motion, crepitus, or locking, clicking, or popping), plus evidence of a meniscal tear on MRI. Guidelines support the use of medial patellofemoral ligament reconstruction for patients with a traumatic acute patellar dislocation. In general, guidelines recommended surgical intervention if the patient fails to adequately respond to conservative treatments after 12 months. Guideline criteria have been met. This injured worker presents with persistent right knee pain and mechanical symptoms following surgical repair of quadriceps tendon rupture. Clinical exam findings are consistent with imaging evidence of a medial meniscus tear and lateral patellar maltracking. Detailed evidence of up to 12 months of reasonable and/or comprehensive

operative and non-operative treatment trial and failure has been submitted. Given the significant functional limitations, patellar findings, and persistent pain, swelling and buckling, the medical necessity of medial patellofemoral ligament reconstruction is supported at the time of meniscectomy. Therefore, this request is medically necessary.

12 post-operative physical therapy visits: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Knee.

Decision rationale: The California Post-Surgical Treatment Guidelines for meniscectomy and ligament reconstruction suggest a general course of 12 post-operative visits over 12 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 6 visits. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. This is the initial request for post-operative physical therapy and, although it exceeds recommendations for initial care, is within the recommended general course. Therefore, this request is medically necessary.