MAXIMUS Federal Services

Case Number:	CM15-0084840		
Date Assigned:	05/07/2015	Date of Injury:	12/30/2013
Decision Date:	06/30/2015	UR Denial Date:	04/23/2015
Priority:	Standard	Application Received:	05/04/2015

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:

The injured worker is a 42-year-old male who sustained an industrial injury on 12/30/13. He was employed as a welding inspector. Injury occurred while he stepped on an uneven surface and his right knee buckled with immediate onset of pain and swelling. Past surgical history was positive for right knee arthroscopy with anterior cruciate ligament (ACL) debridement and shrinkage on 8/8/02. Initial conservative treatment included physical therapy. The 4/8/14 orthopedic report documented right knee exam with moderate effusion, medial and lateral joint line tenderness, positive Mcmurray's, and positive Lachman, pivot shift, and anterior drawer tests. The knee was stable to varus valgus stress. MRI was reviewed and showed a complete rupture of the ACL with tears in vertical fashion of the lateral meniscus at the posterior horn of the red zone, and to a lesser degree in the medial meniscus in the posterior horn red zone. The treatment plan recommended ACL reconstruction with meniscal repair. Records documented that the right knee industrial injury was accepted on 12/26/14. On 4/7/15, authorization was requested for right knee arthroscopic reconstruction with allograft and meniscus repair, twelve post-operative physical therapy sessions, and a CryoCuff cooling machine. The 4/23/15 utilization review non-certified the right knee anterior cruciate ligament reconstruction with allograft and meniscus repair, with associated surgical requests, as there was no current report available to support the medical necessity of surgery. The 5/8/15 orthopedic report cited significant right knee instability with activities of daily living and work activities. Physical exam documented small effusion, medial and lateral joint line tenderness, positive Mcmurray's, and positive Lachman, pivot shift, and anterior drawer tests. The knee was stable to varus valgus stress. MRI showed complete ACL tear with medial and lateral meniscus tear. Authorization was requested for ACL reconstruction with allograft and meniscus repair. Authorization was also requested for post-op physical therapy x 12 visits and a CryoCuff cooling machine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Knee ACL Reconstruction with Allograft (Arthroscopic): Overturned

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), Indications for Surgery, Anterior cruciate ligament (ACL) reconstruction.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg: Anterior cruciate ligament (ACL) reconstruction.

Decision rationale: The California MTUS 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. 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. The Official Disability Guidelines indicated that the use of autograft versus allograft should be surgeon preference. Guideline criteria have been met. This injured worker presents with significant instability interfering with activities of daily living and work activities. Clinical exam findings are consistent with reported imaging evidence of a complete ACL tear. Based on his age, work demands, and imaging evidence of a complete tear, this request is medically necessary.

Meniscus Repair: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Criteria for meniscectomy or meniscus repair and on the Non-MTUS American Academy of Orthopedic Surgery guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345.

Decision rationale: The California MTUS 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. Guideline criteria have been met. This injured worker presents with persistent right knee pain and instability. Clinical exam findings are consistent with reported imaging evidence of medial and lateral meniscus tears. Evidence of reasonable non- operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Post-operative physical therapy x 12: 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: The California Post-Surgical Treatment Guidelines for anterior cruciate ligament reconstruction suggest a general course of 24 post-operative visits over 16 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. 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 request for physical therapy is consistent with guideline recommendations for initial post- operative treatment. Therefore, this request is medically necessary.

Associated surgical service: CryoCuff Cooling 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), Continuous flow cryotherapy.

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 flow cryotherapy.

Decision rationale: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after knee surgery for up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request is not medically necessary.