

Case Number:	CM15-0086688		
Date Assigned:	05/08/2015	Date of Injury:	12/19/2014
Decision Date:	06/12/2015	UR Denial Date:	04/03/2015
Priority:	Standard	Application Received:	05/05/2015

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: Minnesota, Florida
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 45-year-old male sustained an industrial injury on 12/19/14. He subsequently reported left knee pain. Diagnoses include left knee sprain and left anterior cruciate allograft tear. Treatments to date include x-ray testing, MRI, modified work duty, physical therapy and prescription pain medications. The injured worker continues to experience left knee pain. Upon examination, left patella is tender at the base of the patella, McMurray test is negative for meniscal tears, range of motion of the left knee is normal per AMA guidelines and muscle strength is 5/5 left lower extremity in extension and flexion. The treating physician made a request for ACL allograft, removal of a transverse screw, and treatment of the medical meniscus with assistant surgeon [REDACTED]. A prior request for the surgical procedure was certified by utilization review but this new request was non-certified citing CA MTUS guidelines. The IW has responded with a letter explaining his day-to-day activity limitations and the degree of instability related to ACL deficiency. The denial is appealed to an independent medical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

AC Allograph Removal of Screw of Medical Meniscus with Assistant [REDACTED]:
Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 11th Edition, (web), 2013, Low Back, Surgical Assistant.

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

Decision rationale: The injured worker is a healthy 44-year-old male with a long-standing history of difficulties with his left knee. He had an ACL injury in 2005 and underwent allograft reconstruction. In 2008, he underwent arthroscopy of the knee and a loose body was removed. He reinjured his knee in 2011 but did not have surgery. He was able to tolerate normal everyday activities until the injury of 12/19/2014. An MRI scan of the knee revealed complete disruption of the anterior cruciate ligament. Some degree of underlying degenerative change was noted as well, particularly in the lateral compartment. Meniscal tearing and loose body formation was appreciated. Per initial orthopedic evaluation of 1/30/2015, he complains of recurrent pain and swelling in his knee in response to work activities. Mechanical symptoms are reported with occasional sensation of locking. On examination, a trace positive pivot shift was documented. An MRI of the knee revealed complete disruption of the anterior cruciate ligament and altered signal in the posterior horn of the medial meniscus possibly indicating a tear. The tibial interference screw and transverse screws in the distal femur were noted. There was evidence of prior partial lateral meniscectomy. The residual posterior horn was irregular, likely reflective of tearing. There was altered signal in the posterior horn of the medial meniscus representing a degenerative tear. Full-thickness cartilage loss was noted at the posterior aspect of the lateral tibial plateau and weight-bearing aspects of the lateral femoral condyle. A 6 mm intra-articular body was noted at the posterior aspect of the lateral compartment. An x-ray of the left knee dated 12/22/2014 revealed the transverse screw of the distal femur to extend 5-6 mm beyond the medial cortical margin above the medial femoral condyle. Mild degenerative change was noted in the lateral compartment with a 4 mm calcific density. 4 fairly smooth 3-4 mm dystrophic or posttraumatic calcific densities or loose bodies were noted at the central aspect of the lateral joint space with the 2 more medial densities partially superimposed on the inferior lateral femoral notch and on the lateral view 2 of these were visualized just above the posterior tibial plateau. Minimal smooth spurring off the central and medial tibial plateau was noted just medial to the medial tibial spine. California MTUS guidelines indicate anterior cruciate ligament reconstruction is warranted for patients who have significant symptoms of instability. Consideration should be given to the patient's age, normal activity level, and degree of knee instability caused by the tear. In this case, the injured worker has written a letter indicating the degree of instability he is experiencing from day to day. It is clearly interfering with his normal everyday activities, as he is extremely active individual. Anterior cruciate ligament reconstruction had been approved in the past but was non-certified by utilization review this time because of lack of documentation of symptoms of instability. The injured worker has responded with a detailed explanation of his symptoms and clearly has evidence of instability. He also explains his activity level and desire to continue skateboarding. The guidelines indicate surgical reconstruction of the ACL may provide substantial benefit to active patients especially those less than 50 years of age. For patients whose work or life does not require significant loading of the knee and other special conditions, ACL repair may not be necessary. In this case, the medical

necessity of the request for ACL allograft, screw removal, medial meniscus surgery, and Assistant Surgeon, [REDACTED] has been established. This is medically necessary.