

Case Number:	CM14-0127036		
Date Assigned:	08/13/2014	Date of Injury:	01/21/2010
Decision Date:	09/26/2014	UR Denial Date:	08/06/2014
Priority:	Standard	Application Received:	08/11/2014

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 is a 59-year-old female who sustained slip and fall injury on 01/21/10. The medical records provided for review document that the claimant underwent left knee arthroscopy, partial medial meniscectomy, partial lateral meniscectomy and debridement chondroplasty of the lateral femoral condyle and patella on 11/05/12. The office note dated 05/21/14 noted that the arthroscopy determined that the claimant had insufficiency of her anterior cruciate ligament as well as an osteochondral defect of her lateral femoral condyle and that treatment with debridement of the osteochondral lesion and partial meniscectomy addressed the pathology. However, the claimant had ongoing symptoms in her knee, which include giving way, locking, weakness, decreased range of motion, swelling and pain. On examination, she had medial joint line tenderness, 1+ anterior drawer and a 1+ Lachman's with a 1 to 2+ pivot shift. A mild effusion was noted. The intraoperative findings from the 11/05/13 surgery included grade III fibrillation and chondromalacia of the lateral patellar facet. It was noted that there was some laxity both in flexion and extension of the anterior cruciate ligament with probing. However, the claimant did not have a positive pivot shift test under anesthesia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-op Surgical Clearance: 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) ACOEM Chapter 7, page 127 Introduction The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. An independent medical assessment also may be useful in avoiding potential conflict(s) of interest when analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification. When a physician is responsible for performing an isolated assessment of an examinee's health or disability for an employer, business, or insurer, a limited examinee-physician relationship should be considered to exist. A referral may be for: -Consultation: To aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. -Independent Medical Examination (IME): To provide medicolegal documentation of fact, analysis, and well-reasoned opinion, sometimes including analysis of causality. An IME differs from consultation in that there is no doctor-patient relationship established and medical care is not provided. It may be a means of medical clarification or adjudication in which the physician draws conclusions regarding diagnosis, clinical status, causation, work-relatedness, testing and treatment efficacy and requirements, physical capacities, impairment, and prognosis based on available information. The evaluations must be independent, impartial, and without bias. The client often may be the employer, insurer, state authority, or attorney. Citation(s): Harris J, Occupational Medicine Practice Guidelines, 2nd Edition (2004) - pp. 127 Hegmann K, Occupational Medicine Practice Guidelines, 2nd Ed (2008 Revision) - pp. 503;.

Decision rationale: The Expert Reviewer based his/her decision on the Non-MTUS American College of Occupational and Environmental Medicine ACOEM Chapter 7, page 127 The Expert Reviewer's decision rationale: The request for preoperative medical clearance cannot be considered medically necessary.

ACL reconstruction with Achilles allograft left knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation ODG Knee & Leg (updated 06/05/14) Anterior cruciate ligament (ACL) reconstruction ODG Indication for Surgery - Anterior cruciate ligament (ACL) reconstruction.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Knee & Leg chapter: Anterior cruciate ligament (ACL) reconstruction Recommended as indicated below. An examination of all studies that compared operative and conservative treatment of anterior cruciate ligament (ACL) rupture found that outcomes in the operative groups were generally better than in the conservative groups for younger patients. (Hinterwimmer, 2003) (Linko-Cochrane, 2005) Females are more likely than males to have a narrow A-shaped intercondylar notch, and special surgical considerations are required in such

cases. Following ACL reconstruction, female athletes are more likely than male athletes to rupture the contralateral ACL; however, males and females are equally likely to rupture the reconstructed knee. Although self-reported outcomes in the first 2 years following reconstruction are worse for females than for males, longer-term studies demonstrate no difference between males and females. (Sutton, 2013) Morbidity is lower for hamstring autografts than for patellar tendon autografts used for ACL reconstruction. (Biau, 2006) The use of bracing after anterior cruciate ligament (ACL) reconstruction cannot be rationalized by evidence of improved outcome including measurements of pain, range of motion, graft stability, or protection from injury. (Wright, 2007) Most of the roughly 100,000 ACL reconstructions performed each year are for younger patients. Although age has been considered a relative contraindication for ACL surgery in the past, active older patients may respond well to this surgery and should not be ruled out as surgical candidates based solely on their age. It is important to look at their comorbidities, e.g., malalignment and osteoarthritis, because they predict potential problems. (Wulf, 2008) Anterior cruciate ligament (ACL) reconstruction using an allograft has a high failure rate in young, active adults. While there are obvious benefits of using the cadaver ligament, like avoiding a second surgical site on the patient, a quicker return to work and less postoperative pain, for the young patient who is very active, it may not be the right choice. (Luber, 2008) In patients with ACL injury willing to moderate activity level to avoid reinjury, initial treatment without ACL reconstruction should be considered. All ACL-injured patients need to begin knee-specialized physical therapy early (within a week) after the ACL injury to learn more about the injury, to lower the activity level while performing neuromuscular training to restore the functional stability, and as far as possible avoid further giving-way or re-injuries in the same or the other knee, irrespectively if ACL is reconstructed or not. (Neuman, 2008) Patients with anterior cruciate ligament (ACL) injuries may not need surgery. At 2-5 years after injury, muscle strength and function were similar in patients treated with physical therapy and surgical reconstruction or physical therapy only.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS ACOEM Practice Guidelines, Chapter 13 Knee Complaints, page 343-345 and on the Non-MTUS Official Disability Guidelines (ODG); Knee & Leg chapter: Anterior cruciate ligament (ACL) reconstruction. The Expert Reviewer's decision rationale: The California ACOEM Guidelines recommend the "ACL reconstruction is warranted only for patients who have significant symptoms of instability caused by ACL incompetence." The Official Disability Guidelines state that that "outcomes for ACL reconstruction are worse in older patients 50 to 60 years or older. It is noted that age alone should not exclude ACL deficient patients from undergoing reconstructive surgery." The medical records do not document how the intraoperative findings from November of 2013 proved that the ACL was stable enough to not undergo surgical intervention at that setting, but now requires reconstruction. There is no documentation of a new injury or fall since the time of surgery. The documentation indicates that the claimant has had postoperative physical therapy and some additional physical therapy in an attempt to strengthen the musculature around the knee. There is a lack of documentation that a brace has been utilized, which would be recommended at the age of 59 years old prior to considering surgical intervention in the form of ACL reconstruction. There is no recent diagnostic report for review in the form of an MRI or MRA confirming that there is a full thickness ACL tear or that there is any increased degree of laxity compared to the previous diagnostic studies, which failed to confirm an ACL deficient left knee. Taking the medical records provided for review and the

ACOEM Guidelines and Official Disability Guidelines into consideration, the request for the left knee ACL reconstruction with Achilles allograft cannot be considered medically necessary.