

Case Number:	CM14-0168656		
Date Assigned:	10/16/2014	Date of Injury:	02/03/2014
Decision Date:	11/18/2014	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	10/13/2014

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 Orthopaedic 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 30-year-old female sustained an industrial injury on 2/3/14. Injury occurred when she slipped in grease and twisted her right knee. The 2/11/14 right knee x-rays documented mild age accelerated hypertrophic arthritic change involving the medial and lateral compartments. Conservative treatment included activity modification, anti-inflammatory medications, and opioid pain medication. The patient attended at least 18 visits of physical therapy with some improvement in range of motion and increased strength but persistent pain and significant limitation in prolonged weight bearing activities and stairs. The 6/30/14 right knee MRI impression documented multiple knee derangements. A very large knee effusion was present. There was a large marginal hypertrophic spur of the medial aspect of the medial femoral condyle, and moderate spurs of the posterior aspect. There was a large lateral hypertrophic spur of the lateral femoral condyle with small spurs of the posterior aspect and lateral tibial plateau. The patella is severely subluxed laterally. The lateral patellar facet cartilage was severely thinned if not absent in some areas, and the subchondral bone was flattened and edematous. There were moderate hypertrophic spurs of the margins of the trochlear groove. Findings were consistent with a complete tear of the anterior cruciate ligament and partial tear of the posterior cruciate ligaments. The proximal medial collateral ligament is thickened with ill-defined borders and appears stripped from the medial femoral condyle in some areas. The femoral collateral ligament may be completely torn laterally. The tibial tuberosity was fragmented with some ossicles displaced proximally consistent with old Osgood-Schlatter's disease and findings were consistent with on-going inflammation. There was a very large Baker's cyst with soft tissue edema indicative of cyst rupture. The 9/5/14 initial orthopedic report cited continued right knee pain, swelling, and occasional sensation of giving way. She was unable to go up and down stairs or work. Physical exam documented height 5'7", and weight 265 pounds. There was excellent right

knee range of motion with some slight hyperextension equal bilaterally. There was mild crepitation with ballottement of the patella and range of motion. There was pain with manipulation but no frank instability of the patellofemoral joint. Q-angle was difficult to measure but appeared excessive on x-rays. There was a slight valgus attitude of both lower extremities but this could be visual secondary to weight. There were negative pivot shift and Lachman's tests, and no varus/valgus instability. There was tenderness over the medial and lateral joint line with increased discomfort with McMurray's. X-rays showed good maintenance of the articular height of the medial and lateral compartments. There was a minor lateral tilt to the patella on sunrise view. Peripheral osteophytes were present on both medial and lateral femoral condyles. There was some narrowing of the patellofemoral joint height and ossification in the area of the tibial tuberosity consistent with old Osgood Schlatter's. Patella Alta was present. The diagnosis was traumatic degenerative joint disease right knee, Patella Alta, and patellofemoral malalignment. The treatment plan recommended arthroscopy and debridement with possible lateral release. The treating physician opined the joint surfaces needed to be examined but would not go further in terms of realignment than maybe a lateral release. The patella was in an identical position bilaterally with no degenerative changes in the left knee. Lateral release would not be done for instability reasons but for pain if indicated at time of arthroscopy. The 9/15/14 utilization review denied the request for lateral release and debridement given body mass index (41.7), bilateral findings, lack of instability, and stated benefit with physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right knee lateral release and debridement: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345. Decision based on Non-MTUS Citation ODG Indications for surgery-Lateral retinacular release

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345,347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Lateral retinacular release, Chondroplasty

Decision rationale: The California MTUS 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. The Official Disability Guidelines criteria for chondroplasty include evidence of conservative care (medication or physical therapy), plus joint pain and swelling, plus effusion or crepitus or limited range of motion, plus a chondral defect on MRI. Indications for lateral retinacular release include physical therapy or medications, and pain with sitting or patellar/femoral movement or recurrent dislocations. Clinical exam findings should include lateral tracking of the patella, recurrent effusion, patellar apprehension, synovitis with or without crepitus, or Q angle greater than 15 degrees. Imaging findings of abnormal patellar tilt are generally required. Guideline criteria have been met. This patient presents with significant functional limitation precluding return to work. There is joint pain, swelling, effusion, crepitus and imaging evidence of chondromalacia. There is an increased Q-angle on x-rays and patellar tilt. Evidence of more than 6 months of a recent,

reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request of right knee lateral release and debridement is medically necessary and appropriate.