

<b>Case Number:</b>	CM14-0138861		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	06/01/2014
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	07/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2014

### 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. 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:

The injured worker is an obese 340 pound 26-year-old male. The date of injury was 6/1/2014. He stated that his right knee gave out when he jumped down from a luggage ramp at the airport. He experienced pain and his knee "came out of place and then went back into place". MRI scan of the right knee dated 7/10/2014 revealed an acute complete tear of the anterior cruciate ligament. There was a tear of the posterior horn and body of the medial meniscus with a flap of meniscal tissue displaced superior to the posterior horn. There were bony contusions involving the posterior portion of the lateral tibial plateau, the posterior portion of the medial tibial plateau and the posterior portion of the medial femoral condyle. In the medial compartment there was a chondral flap tear involving the posterior weight bearing surface of the medial femoral condyle with full-thickness cartilage loss. The orthopedic consultation dated 7/23/2014 indicated subjective complaints of an achy pain worse with activity. He denied any buckling or giving way but admitted to not being very active. Treatment had included rest, medications, and a lightweight brace. He related a history of playing high school and junior college football where he had "sprained" his knee in the past. He stated that he had undergone past MRIs, which were normal. On examination, the IW was 5 feet 11 inches tall and weighed 340 pounds. His gait was normal. His range of motion was 0-135°. McMurray's revealed positive medial and lateral joint line tenderness. He had a positive Lachman and a positive anterior drawer. The assessment was ACL tear, acute, symptomatic; Medial meniscus tear, symptomatic; Contusion knee, symptomatic. Treatment options were discussed and the injured worker elected to proceed with surgery. There is a follow-up note dated September 18, 2014. The injured worker was

continuing to complain of pain and popping in the right knee. The pain level was reported to be 7/10. On examination, there was tenderness posteriorly and medially with a positive anterior drawer sign. The last follow-up note is dated 11/6/2014. The pain level was reported to be 4/10. He was not working. The provider requested authorization for right knee arthroscopy, ACL reconstruction, medial meniscectomy and debridement on 7/24/2014. On 7/30/2014, utilization review noncertified the request citing MTUS guidelines. There was no documentation of pain level and no symptoms of instability were documented. There was no limitation of range of motion. The work did not require significant loading of the knee. As such, ACL reconstruction was not necessary. The available documentation at that time was not complete. Subsequent notes document the pain levels as well as mechanical symptoms. The disputed surgical request was 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:

**Right knee arthroscopy ACL reconstruction medial meniscectomy and debridement,:**  
Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints  
Page(s): 343, 344, 345.

**Decision rationale:** California MTUS guidelines indicate anterior cruciate ligament reconstruction generally is warranted only for patients who have significant symptoms of instability caused by the ACL incompetence. The injured worker does not describe frequent episodes of giving way or falls during activities that involve knee rotation. However, he was limiting his activities and at the time of the last examination was not working. The physical examination revealed clear signs of instability as shown by positive Lachman, and anterior drawer. The pivot shift test was not documented. The clinical findings were confirmed with MRI evidence of a complete tear of the anterior cruciate ligament. The guidelines indicate that 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. The IW is clearly young and active. Documentation indicates that he used to play football. The medical records are not complete in that the last available note is dated 11/6/2014. The progress notes indicate that he was continuing to experience popping in the knee and pain, which was 4/10 at that time as he was not working. The guidelines indicate that 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. However, the injured worker is obese and his body weight is 340 pounds which causes considerable loading of the knee. In addition to the torn ACL, he also has a displaced meniscal tear involving the medial meniscus associated with complaints of popping in the joint and a small effusion on the MRI scan. There is also a chondral defect of the medial femoral condyle noted. Arthroscopic partial meniscectomy usually has a high success rate for cases in which there is a clear evidence of meniscus tear associated with mechanical symptoms like popping and recurrent effusion. Examination findings revealed tenderness at the posteromedial joint line

consistent with the location of the tear. As such, the request for anterior cruciate ligament reconstruction and medial meniscectomy and debridement is supported by guidelines and the medical necessity of the request has been established. The prior UR denial was based upon insufficient medical records. Additional records indicating persisting mechanical symptoms and pain complaints have since been provided warranting surgical reconstruction. Therefore, the request is medically necessary.

**Surgical assistant MD or RN first asst: Overturned**

**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 Surgeons 2013 Assistant at Surgery Consensus.

**Decision rationale:** According to the American College of Surgeons, the first assistant during a surgical operation should be a trained individual who is able to participate in and actively assist the surgeon in completing the operation safely and expeditiously by helping to provide exposure, maintaining hemostasis, and serve other technical functions. The qualifications of the person in this role may vary with the nature of the operation, the surgical specialty, and the type of hospital or ambulatory surgical facility. According to the 2013 assistant at surgery consensus, anterior cruciate ligament reconstruction almost always needs a surgical assistant. As such, the request for a surgical assistant is supported and is medically necessary.

**Physical Therapy times 12 Visits; Right Knee Post-Op: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25.

**Decision rationale:** California MTUS postsurgical treatment guidelines indicate 24 visits over 16 weeks for anterior cruciate ligament reconstruction. The postsurgical physical medicine treatment can be up to 6 months. The initial course of therapy is one-half of these visits, which is 12. The request as stated is for 12 physical therapy visits, which is appropriate and medically necessary.

**CPM machine rental 7-14 days: 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 ODG: Section: Knee, Topic: Continuous Passive Motion.

**Decision rationale:** ODG guidelines recommend continuous passive motion devices in the acute hospital setting for anterior cruciate ligament reconstruction but only for inpatient care. For home use, the criteria do not include anterior cruciate ligament reconstruction. As such, the request for CPM rental is not supported, and therefore, is not medically necessary.

**Cold therapy unit rental 7-14 DAYS:** 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 ODG: Section: Knee, Topic: Continuous flow cryotherapy.

**Decision rationale:** ODG guidelines recommend continuous-flow cryotherapy as an option after knee surgery. It reduces pain, swelling, inflammation, and need for narcotics after surgery. Its use is generally recommended for 7 days. The request as stated is for 7-14 days rental of the cold therapy unit which is not supported by guidelines and as such, is not medically necessary.

**ACL brace post-op right knee:** 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 ODG: Section: Knee, Topic: Knee brace.

**Decision rationale:** ODG guidelines indicate the use of bracing after anterior cruciate ligament reconstruction cannot be rationalized by evidence of improved outcome including measurements of pain, range of motion, graft stability, or protection from injury. As such, a custom fabricated ACL brace is not supported by guidelines. However, a prefabricated knee brace may be appropriate. The request as stated is for an ACL brace, which is not supported, and therefore, not medically necessary.