

Case Number:	CM13-0021412		
Date Assigned:	10/11/2013	Date of Injury:	02/28/2003
Decision Date:	03/12/2014	UR Denial Date:	08/19/2013
Priority:	Standard	Application Received:	09/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in orthopedic surgery and is licensed to practice in Texas. 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 physician 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:

The patient is a 52-year-old female who reported an injury on 02/28/2003. The patient is diagnosed with right elbow epicondylitis, bilateral carpal tunnel syndrome, bilateral knee arthroscopies, and bilateral knee arthrosis. The patient was seen by [REDACTED] on 06/04/2013. The patient reported bilateral knee pain as well as low back pain. Physical examination revealed severe bilateral knee tenderness, medial joint line tenderness, decreased range of motion with crepitus, positive pivot shift, thickness to the lower extremity with diffuse increased girth due to swelling of the soft tissue, cramping in the gastrocnemius and anterior tibialis, and tenderness with spasm and tightness of the lumbar spine. Treatment recommendations included an additional surgical request for a total knee arthroplasty.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right total knee arthroplasty: 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) Knee & Leg Chapter, Knee Joint Replacement

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, Knee Joint Replacement

Decision rationale: The California MTUS/ACOEM Practice Guidelines state referral for surgical consultation may be indicated for patients who have activity limitation for more than 1 month and failure of exercise programs to increase range of motion and strength of the musculature around the knee. The Official Disability Guidelines state prior to a knee arthroplasty, patients should be treated with conservative therapy including exercise, medications, viscosupplementation injections, or steroid injections. As per the clinical notes submitted, the patient's latest MRI of the right knee was dated 11/01/2012, and indicated questionable degenerative tear involving the mid and anterior horn of the medial meniscus, poor visualization of the ACL, thinning of the articular cartilage and the medial compartment and acute narrowing of the medial compartment, and moderate knee effusion. There is no documentation of a body mass index less than 35. There were also no standing x-rays submitted for review. There is also no documentation of a failure to respond to previous conservative treatment including medications, viscosupplementation injections, or steroid injections. Based on the clinical information received, the request for Right Knee Total Arthroplasty, Inpatient is non-certified.

Motorized Cold therapy unit: 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 Official Disability Guidelines (ODG) Knee & Leg Chapter, Continuous Flow Cryotherapy

Decision rationale: The Official Disability Guidelines state continuous flow cryotherapy is recommended after surgery, but not for non-surgical treatment. Postoperative use generally may be up to 7 days. As the patient's surgical procedure has not been authorized, the current request cannot be determined as medically appropriate. Therefore, the request for Motorized Cold therapy Unit is non-certified.

Post-surgical Care: 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)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state physician followup is appropriate when a release to modified, increased, or full duty is needed, or after appreciable healing or recovery can be expected, on average. As the patient's surgical procedure has not been authorized, the current request for postsurgical care is also not medically necessary. Therefore, the request for Post-surgical Care is non-certified.

Front Wheeled Walker: 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)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Durable Medical Equipment, Walking Aids

Decision rationale: The Official Disability Guidelines state durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. Walking aids are recommended for specific indications. As the patient's surgical procedure has not been authorized, the current request for Front Wheeled Walker is non-certified.

Post-operative Physical Therapy, Right Knee, 2 times a week for 4 weeks: Upheld

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): 24.

Decision rationale: The California MTUS Guidelines state initial course of therapy means one-half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations. Postsurgical treatment following a knee arthroplasty includes 24 visits over 10 weeks. As the patient's surgical procedure has not been authorized, the current request for postoperative physical therapy is not medically necessary. Therefore, the request for Post-operative Physical Therapy, Right Knee, 2 times a week for 4 weeks is non-certified.