

Case Number:	CM13-0035840		
Date Assigned:	12/13/2013	Date of Injury:	02/04/2011
Decision Date:	09/16/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/18/2013

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 Surgeon 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 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:

The injured worker is a 48-year-old male who reported an injury on 02/04/2011 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to the bilateral knees and shoulders. The injured worker's treatment history for the left knee included physical therapy, multiple medications, and corticosteroid injections. The injured worker underwent an MRI on 02/22/2014 that documented there was trace joint effusion and evidence of a possible medial meniscus tear. The injured worker's surgical history included left knee arthroscopic surgery, shoulder arthroscopic surgery, and carpal tunnel release. The injured worker was evaluated on 09/24/2014. Physical findings of the left lower extremity included medial joint line tenderness and restricted range of motion described as 110 degrees in flexion and zero degrees in extension with painful range of motion and a positive patellofemoral grind test and crepitus. The injured worker's diagnoses included right shoulder rotator cuff syndrome, right frozen shoulder/adhesive capsulitis, status post right wrist carpal tunnel release, status post left knee surgery, left knee end stage osteoarthritis, medial knee meniscus tear, right knee internal derangement and insomnia. A request was made for a left total knee arthroplasty. A request for authorization for left knee; however, no clinical examination findings, interim, treatment, or diagnostic measures were provided from within the last year. There is no indication that this is a retrospective request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Total Knee Replacement (left knee): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 343. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee Chapter, Knee Joint Replacement.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg chapter, Knee replacement.

Decision rationale: The requested total knee replacement is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not specifically address the surgical intervention. Official Disability Guidelines recommend this surgical procedure for patients who are older than 50 years with a body mass index of less than 35 that have failed all nonsurgical options and have severely limited range of motion and decreased function secondary to severe osteoarthritis, consistent with pathology identified on an imaging study. The clinical documentation submitted for review does indicate that the injured worker has received several treatment modalities of conservative therapy. However, the injured worker is under the age of 50, and the injured worker's body mass index was not identified within the documentation. Furthermore, the injured worker has range of motion from zero to 110 degrees in flexion based on the submitted documentation. This is not classified in the severe range. Total knee arthroplasty is recommended for injured workers who have less than 90 degrees of flexion on range of motion. There were no exceptional factors provided to support extending treatment beyond the guideline recommendations. The clinical documentation included an MRI dated 02/22/2013 that did not specifically identify a compartmental osteoarthritis that would require surgical intervention. As such, the requested total knee replacement is not medically necessary or appropriate.

Inpatient Hospital Stay (2-3 days): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Pre-Operative Medical Clearance: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-Operative Physical Therapy (12-sessions, 3 times per week for 4 weeks, for the left knee): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Lovenox Injections (for 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 cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Home Health Aide (3-hours per day, 5-days per week, for 4-weeks): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

A walker (for post-operative use): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

A left knee brace (for post -operative use): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.