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| Case Number: | CM13-0047797 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 09/10/2009 |
| Decision Date: | 03/25/2014 | UR Denial Date: | 10/03/2013 |
| Priority: | Standard | Application Received: | 11/04/2013 |

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, has a subspecialty in Hand 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 70-year-old male who reported an injury on 09/10/2009 due to cumulative trauma while performing normal job duties. The patient reportedly sustained injury to multiple body parts to include the cervical spine, right shoulder, and bilateral knees. The patient's most recent clinical evaluation documented tenderness to palpation of the left knee with decreased range of motion and a positive McMurray's sign. Evaluation of the right shoulder documented tenderness to palpation with decreased range of motion and a positive Speed's and positive Codman's sign. The patient's diagnoses included cervical spine sprain/strain, right shoulder sprain, osteoarthritis bilateral knees, status post left knee arthroscopy, sleep disorder, right knee tear of the medial and collateral ligament. The patient's treatment recommendations included an MRI of the right shoulder to rule out internal derangement, and consultation for consideration of arthroscopy or total knee replacement of the left knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

Decision rationale: The requested MRI of the right shoulder is not medically necessary or appropriate. American College of Occupational and Environmental Medicine recommend imaging studies for patients who have persistent deficits that have failed to respond to conservative management when surgical intervention is being considered. The clinical documentation submitted for review fails to provide any evidence that the patient has received any conservative treatment to the right shoulder. Although the patient has had persistent pain complaints, there is no documentation of active therapy or injection therapy for the right shoulder. As such, the requested MRI of the right shoulder is not medically necessary or appropriate.

right knee arthroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345.

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

Decision rationale: The requested right knee arthroscopy is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommend surgical intervention when the patient has significant deficits in functional capabilities and a lesion is identified by both physical and imaging studies that would benefit from surgical intervention. The clinical documentation submitted for review does not provide any evidence that the patient has exhausted physical therapy for the right knee. Additionally, an imaging study showing a lesion that would benefit from surgical intervention for the right knee was not provided for review. The patient was evaluated on 07/26/2013 and examination of the right knee revealed tenderness to palpation medially with no evidence of effusion, instability, and a negative McMurray test and Apley test. Therefore, the need for surgical intervention is not clearly established. As such, the right knee arthroscopy is not medically necessary or appropriate.

left knee arthroplasty interpretation: 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 Chapter.

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

Decision rationale: The requested left knee arthroplasty interpretation is not medically necessary or appropriate. Official Disability Guidelines recommend total knee arthroplasty for patients who have significantly limited range of motion of less than 90 degrees and evidence of severe tricompartmental osteoarthritis. The clinical documentation submitted for review does provide an interpretation of an MRI that documents tricompartmental osteoarthritis. However, it was only classified as mild to moderate. An independent interpretation of that MRI was not provided for review. Additionally, the patient was examined on 07/26/2013 with range of motion

identified as -4 degrees in extension and 120 degrees in flexion. This range of motion does not support severe osteoarthritis. As such, the requested left knee arthroplasty interpretation is not medically necessary or appropriate.