

<b>Case Number:</b>	CM13-0059974		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	01/26/2008
<b>Decision Date:</b>	04/01/2014	<b>UR Denial Date:</b>	11/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2013

### 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 58-year-old male who reported an injury on 01/26/2008. The mechanism of injury was noted to be the patient was walking on muddy ground carrying equipment when his left leg slipped into a concrete joint. The patient had a right knee total arthroplasty in 2008 and a revision on a date that was not supplied in documentation. The patient was treated with physical therapy and Viscosupplementation. The patient's chief complaint was constant pain in the right knee. The pain was rated an 8 during the day on a scale of 1 to 10. The pain was aggravated by walking and alleviated by Norco. The activities of daily living that were painful or difficult include walking. Physical examination revealed the patient was 5 feet and 7 inches tall and weighed 270 pounds. The patient's BMI was noted to be 42.33. The evaluation of the bilateral knees indicated that there were areas of point tenderness to palpation. The patient's right knee range of motion was -15 to 30 degrees, passive flexion was 40 degrees and the patient had good ankle motion. The 3-view x-ray taken in the office of the right knee revealed satisfactory position and alignment of the prosthesis. The patient's diagnoses were noted to be arthrofibrosis, right knee status post right total arthroplasty, and revision of right knee arthroplasty performed by another provider. The patient had morbid obesity of 42.33. Per the office note of 10/22/2013, the patient had a CT scan on 01/22/2013 which revealed complete knee arthroplasty without evidence of loosening or foreign body reaction and abnormal rotational alignment of the femoral component with respect of the tibial plateau. The request was made for a right knee total arthroplasty with synovectomy, peri-articular injection, postoperative physical therapy, CPM, and multiple pre-operative tests.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right total knee arthroplasty revision: 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 ODG, Knee & Leg Chapter, Knee Joint Replacement

**Decision rationale:** Official Disability Guidelines indicate revision of a total knee arthroplasty is an effective procedure for failure of the originally approved arthroplasty. Official Disability Guidelines' indications for surgery for a total knee joint replacement include documentation of conservative care including medications and Viscosupplementation injections or steroid injections; plus, limited range of motion less than 90 degrees and night time joint pain and no relief with conservative care and documentation of current functional limitations demonstrating necessity of intervention; plus, over 50 years of age and body mass index of less than 35; plus, osteoarthritis on standing x-rays or previous arthroscopy. Clinical documentation submitted for review indicated the patient had treatment with physical therapy and Viscosupplementation. The patient had limited range of motion that was decreased. There was lack of documentation of night time joint pain and no pain relief with conservative care. The patient indicated the pain was relieved by medications. Additionally, the patient has a body mass index of 42.33 and as such, the requested surgery would not be medically necessary or approved. Given the above, the request for right revision total knee arthroplasty is not medically necessary.

**Revision right total knee arthroplasty with synovectomy: 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 ODG, Knee & Leg Chapter, Knee Joint Replacement

**Decision rationale:** Official Disability Guidelines indicate revision of a total knee arthroplasty is an effective procedure for failure of the originally approved arthroplasty. Official Disability Guidelines' indications for surgery for a total knee joint replacement include documentation of conservative care including medications and Viscosupplementation injections or steroid injections; plus, limited range of motion less than 90 degrees and night time joint pain and no relief with conservative care and documentation of current functional limitations demonstrating necessity of intervention; plus, over 50 years of age and body mass index of less than 35; plus, osteoarthritis on standing x-rays or previous arthroscopy. Clinical documentation submitted for review indicated the patient had treatment with physical therapy and Viscosupplementation. The patient had limited range of motion that was decreased. There was lack of documentation of night time joint pain and no pain relief with conservative care. The patient indicated the pain was relieved by medications. Additionally, the patient has a body mass index of 42.33 and as such,

the requested surgery would not be medically necessary or approved. Given the above, the request for right revision total knee arthroplasty is not medically necessary.

**peri-articular injection:** 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.

**Postoperative physical therapy:** 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.

**Rental of a continuous passive motion device:** 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 items/services are medically necessary.

**Preoperative electrocardiogram:**

**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.

**Preoperative CBC lab testing:** 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.

**preoperative Chem 14 panel:** 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.

**preoperative MRSA nasal swab:**

**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.