

Case Number:	CM14-0010448		
Date Assigned:	05/30/2014	Date of Injury:	07/17/1995
Decision Date:	07/25/2014	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	01/24/2014

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. The expert 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 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 72-year-old male who reported an injury on 07/17/1995. The mechanism of injury was not specifically stated. The current diagnoses include right anteromedial knee pain secondary to posttraumatic osteoarthritis and history of right knee arthroscopy in 2000. The injured worker was evaluated on 06/18/2013 with complaints of right knee pain and activity limitation. It is noted that the injured worker has been previously treated with hyaluronic acid injections. Physical examination revealed tenderness to palpation over the medial and anteromedial aspects of the knee, positive palpable patellofemoral crepitus, decreased extension, full flexion, 5/5 strength, and normal motor and sensory examination. X-rays obtained in the office on that date indicate a 3.5 mm medial joint space with slight irregularity, patellofemoral medial trochlea degeneration with patellofemoral narrowing, and normal lateral compartment. Treatment recommendations at that time included a bicondylar partial knee replacement with a preoperative CT scan and preoperative medical clearance.

IMR ISSUES, DECISIONS AND RATIONALES

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

UNICOMPARTMENT PARTIAL RIGHT KNEE REPLACEMENT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 11th Edition, 2013, Knee, Bicompartamental knee 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 Knee & Leg Chapter, Unicompartmental knee replacement, Knee Joint Replacement.

Decision rationale: ACOEM Guidelines state a referral for surgical consultation may be indicated for patients who have activity limitation for more than 1 month and a failure of exercise programs to increase range of motion and strength of the musculature around the knee. The Official Disability Guidelines state a unicompartmental knee replacement is recommended among patients with knee osteoarthritis that is restricted to a single compartment. Conservative treatment should include exercise therapy, medications, and viscosupplementation or steroid injections. Knee arthroplasty is also indicated for patients over 50 years of age with a body mass index of less than 35. As per the documentation submitted, the injured worker has been previously treated with hyaluronic acid injections. However, it is noted that the requesting physician recommends a bicondylar partial knee replacement. The injured worker's MRI of the right knee on 03/27/2013 indicated tricompartmental osteoarthritis. A previous peer to peer discussion was held with the requesting physician, who indicated that a total knee replacement was more appropriate for this patient given his age and multiple medical comorbidities. Therefore, the medical necessity for the requested procedure has not been established. As such, the request is not medically necessary and appropriate.

CT SCAN RIGHT LOWER EXTREMITY(PRE-OPERATIVE): 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(INTERNIST): 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.

LABS-COMplete BLOOD COUNT(CBC), BASIC METABOLIC PANEL(BMP), PROTHROMBIN TIME (PT), PARTIAL THROMBOPLASTIN TIME(PTT): 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.

CHEST X-RAY: 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.

ELECTROCARDIOGRAM (EKG): 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.