

Case Number:	CM14-0017698		
Date Assigned:	04/16/2014	Date of Injury:	02/19/2013
Decision Date:	06/04/2014	UR Denial Date:	01/31/2014
Priority:	Standard	Application Received:	02/12/2014

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 Arizona. 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 patient is a 57-year-old female with a date of injury on 2/19/2013. As a result of the injury the patient is complaining of severe pain in her right knee as well as constant upper and lower back pain. Her pain level is a 6-8/10 without medication and she also complains of frequent pain and numbness in the right leg. The patient underwent arthroscopic surgery of the right knee on 5/20/2013. She had a partial medial meniscectomy at that time. Subsequently, she sustained a fall on 6/2/2013 when her leg gave out on her. She felt a twist and a pop and had an increase in her knee pain. She complained of pain, weakness, buckling, and an effusion of the right knee. There was pain with full flexion and extension of the knee and the patient had a positive McMurray test. The patient was diagnosed as having a medial and lateral meniscal tear. Request was made for a repeat arthroscopy of the right knee. On 10/8/2013 the patient had a repeat arthroscopy of the right knee. The postoperative findings included grade 3-4 degenerative changes of the medial femoral condyle and tibial plateau. There was grade 3-4 chondromalacia changes of the patella. There was a tear of the posterior medial portion of the medial meniscus and a hemorrhagic synovitis. Follow-up visit on 10/17/2013, states the patient was complaining of anxiety and insomnia. At that time a request for psychological evaluation was placed. During this same time frame the patient's chronic upper and lower back pain was being treated by a pain management physician with a combination of medication, and trigger point injections. He describes the patient has experiencing panic and anxiety attacks and that she was having constant pain in her right knee. She is also having constant pain in her upper and lower back with pain and numbness in her right leg. There was limitation of spinal motion with multiple myofascial trigger points. There is a decreased sensation to touch and pinprick in the lateral aspect of the right calf muscle testing was not done due to severe knee pain. Ankle jerks were absent bilaterally. An MRI scan of the lumbar spine was done on 8/2/2013. It revealed degenerative

disc disease at L3-L4, L4-L5 and L5-S1. At L3-L4, the neural foramen were patent and there was minimal compromise of the spinal canal, at L4-L5 the neural foramen were patent and there was minimal compromise of the spinal canal but there was some sclerosis of the endplates signifying degenerative disease. At L5-S1 there was narrowing of the intervertebral space with some indentation of the dura and this extended slightly to the right. An electrodiagnostic study was done on 9/4/2013 and it was interpreted as a normal study. Orthopedic examination of November 21, 2013, the patient states that overall she is doing okay; however, she is battling anxiety and depression. She still had medial lateral joint line tenderness but had a full range of motion of her knee. She was going to start physical therapy and she was to continue her home exercise program. MRI scan of the right knee was done on 12/13/2013. It was interpreted as showing a decrease in the suprapatellar joint effusion and there were findings most consistent with a tear of the posterior horn medial meniscus. No cruciate ligament tear was seen. There was no description of the joint surfaces or the extent of degenerative changes. Orthopedic examination of 1/16/2014, states the patient was only able to complete 2 sessions of physical therapy. She still complained of right knee pain. She has medial and lateral joint line tenderness but full range of motion of the knee. On 1/22/2014, the pain management provider referencing the most recent MRI stated that the patient was now in need of a total knee replacement.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT TOTAL KNEE REPLACEMENT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 329-360.

Decision rationale: The MTUS/ACOEM Guidelines recommends psychological evaluation in the case of chronic pain in order to evaluate the role anxiety and or depression may have in exacerbating or maintaining the patient's complaints. The Official Disability Guidelines (ODG) recommends conservative therapy and medication initially before considering knee arthroplasty. The ODG state that the patient should have limited range of motion for a total knee replacement. In this case, the patient is still convalescing from her latest knee arthroscopy and has only had 2-3 physical therapy sessions. The orthopedic evaluation described the patient is having full range of motion of her knee. There is some discrepancy between the evaluation done by the orthopedic surgeon and the pain management physician. According to the the orthopedic surgeon, the patient states that the patient reports that she feels to be doing okay. However, the pain management physician states that the patient has severe constant knee pain. The pain management physician references the latest MRI scan when he makes a recommendation for total knee replacement. However, the MRI scan does not address the issue of degenerative changes of the articular surface. Additionally, there is no documentation of nocturnal pain and there is no description of the functional limitations demonstrating necessity for intervention. There is documentation of psychological factors which may be affecting the patient's perceptions

of pain. Finally, the orthopedic provider has not recommended total knee arthroplasty yet. The request for right total knee replacement is not medically necessary and appropriate.

LUMBAR EPIDURAL STEROID INJECTION AT L5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections, Page(s): 46.

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines, the criteria for use of epidural steroid injections is a radiculopathy that is documented by physical examination and corroborated by imaging studies and or electrodiagnostic testing. In this case, the physical examination did not document a radiculopathy. There was no documentation of straight leg raise, muscle testing was not documented, and deep tendon reflexes were not documented. Electrodiagnostic studies were normal. MRI mentioned no nerve root compression or compromise and the foramen were patent. Therefore, the request for lumbar epidural steroid injection at L5 is not medically necessary and appropriate.