Case Number:	CM14-0123766		
Date Assigned:	08/08/2014	Date of Injury:	09/24/2006
Decision Date:	09/11/2014	UR Denial Date:	07/31/2014
Priority:	Standard	Application Received:	08/05/2014

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 California. 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:

This is a 53-year-old gentleman who was injured on 09/24/06. Records for review indicate continued complaints of pain in the left knee. His current diagnosis of rotator cuff (RC) arthritis is to the left knee. The injury occurred after a slip and fall at work. Previous MRI report of 10/26/12 showed marked medial compartment degenerative change with loss of cartilage. The claimant has been treated conservatively with most recent clinical report of 06/27/14 showing continued complaints of pain about the knee with positive medial joint line tenderness, negative McMurray's testing, no instability and restricted motion at endpoints. There is no clear documentation of prior conservative care. There is no documentation of this individual's body mass index. The request was for operative intervention to include arthroplasty for the individual's diagnosis of osteoarthritis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inpatient: Left Total Knee Arthoplasty,Body Part: Left Knee: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, TREATMENT INDEX, 12TH EDITION (WEB), 2014,KNEE AND LEG CHAPTER, KNEE JOINT REPLACEMENT; LOW BACK CHAPTER, PREOPERATIVE TESTING.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-- Official Disability Guidelines Treatment in Worker's Comp , 18th Edition, 2013 Updates: knee procedure - Knee joint replacementRecommended as indicated below. Total hip and total knee arthroplasties are well accepted as reliable and suitable surgical procedures to return patients to function. The most common diagnosis is osteoarthritis. Overall, total knee arthroplasties were found to be quite effective in terms of improvement in health-related quality-of-life dimensions, with the occasional exception of the social dimension. Age was not found to be an obstacle to effective surgery, and men seemed to benefit more from the intervention than did women. (Ethgen, 2004) Total knee arthroplasty was found to be associated with substantial functional improvement. (Kane, 2005) Navigated knee replacement provides few advantages over conventional surgery on the basis of radiographic end points. (Bathis, 2006) (Bauwens, 2007) The majority of patients who undergo total joint replacement are able to maintain a moderate level of physical activity, and some maintain very high activity levels. (Bauman, 2007) Functional exercises after hospital discharge for total knee arthroplasty result in a small to moderate short-term, but not long-term, benefit. In the short term physical therapy interventions with exercises based on functional activities may be more effective after total knee arthroplasty than traditional exercise programs, which concentrate on isometric muscle exercises and exercises to increase range of motion in the joint. (Lowe, 2007) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense physical therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. (Larsen, 2008) In this RCT, perioperative celecoxib (Celebrex) significantly improved postoperative resting pain scores at 48 and 72 hrs, opioid consumption, and active ROM in the first three days after total knee arthroplasty, without increasing the risks of bleeding. The study group received a single 400 mg dose of celecoxib, one hour before surgery, and 200 mg of celecoxib every 12 hours for five days. (Huang, 2008) Total knee arthroplasty (TKA) not only improves knee mobility in older patients with severe osteoarthritis of the knee, it actually improves the overall level of physical functioning. Levels of physical impairment were assessed with three tools: the Nagi Disability Scale, the Instrumental Activities of Daily Living Scale (IADL) and the Activities of Daily Living (ADL) Scale. Tasks on the Nagi Disability Scale involve the highest level of physical functioning, the IADL an intermediate level, and the ADL Scale involves the most basic levels. Statistically significant average treatment effects for TKA were observed for one or more tasks for each measure of physical functioning. The imp

Decision rationale: MTUS Guidelines were silent based on Official Disability Guidelines criteria. A left total knee arthroplasty would not be indicated. This individual gives no clinical findings of prior conservative care including injectable therapy to the left knee. There is also no clear documentation of the claimant's body mass index. Guidelines in regards to arthroplasty would support surgery if there is evidence of failed conservative care including corticosteroid and viscosupplementation injections, an age greater than 50 and a body mass index of fewer than 35. Without completely satisfying guideline criteria, the need for operative intervention in this individual would not be medically necessary and appropriate.