

Case Number:	CM14-0151953		
Date Assigned:	10/01/2014	Date of Injury:	01/14/2013
Decision Date:	11/20/2014	UR Denial Date:	09/04/2014
Priority:	Standard	Application Received:	09/17/2014

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 55-year-old female with a date of injury of 1/14/2013. She was employed as a packer at the time of injury. The mechanism of injury was not documented. Injuries were reported to the left knee and ankle, left shoulder, low back, and neck. The 8/14/14 treating physician report cited sharp and burning left knee pain. The physical exam documented positive varus alignment, crepitus, and effusion. There was medial and lateral joint line tenderness. The lower extremity motor strength was 5/5. The diagnosis was left knee degenerative joint disease. The standing x-rays demonstrated 4 mm medial and 2 mm lateral joint space narrowing. She had failed conservative treatment, including physical therapy, medications, and injections. The injured worker was making progress with her dental cleaning. The plan was to proceed with left total knee replacement when cleared by her doctor. The 9/4/14 utilization review denied the left total knee replacement and associated requests based on an absence of dental clearance for surgery. The 9/11/14 treating physician report cited constant grade 8/10 left knee pain, increased by prolonged walking, standing, or knee bending. The pain was improved by rest. The physical exam documented her height at 5'1" and weight at 157 pounds. The right knee range of motion was 0-100 degrees with positive lateral joint line and patella tenderness, and minimal medial joint line tenderness. There was no effusion. Quadriceps atrophy was present. The lower extremity sensation, strength, and reflexes were normal. The diagnosis was left knee degenerative joint disease. The left knee standing x-rays showed diminished joint space both medially and laterally. The worker was having difficulty taking anti-inflammatory medications due to gastroesophageal reflux disease. Voltaren gel was prescribed. The injured worker was being evaluated by a dentist for treatment of her three loose infected teeth. She could not undergo total knee replacement at the present time due to her teeth. Authorization of the total knee replacement would be requested when the dental problem has resolved.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left total knee replacement: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), Knee joint replacement

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines does not provide recommendations for total knee arthroplasty. The Official Disability Guidelines recommend total knee replacement when surgical indications are met. Specific criteria for knee joint replacement include exercise and medications or injections, limited range of motion (less than 90 degrees), night-time joint pain, no pain relief with conservative care, documentation of functional limitations, age greater than 50 years, a body mass index less than 35, and imaging findings of osteoarthritis. The current peer-reviewed guidelines recommend variables be addressed in the pre-operative period to reduce potential for infection, including optimizing medical conditions. Preoperative measures include management of workers colonized by Staphylococcus aureus, nutritional optimization, and management of medical comorbidities. The guideline criteria have not been met. The standing x-rays documented joint space narrowing but does not specifically evidence osteoarthritis. The current range of motion exceeds the guideline criterion. The injured worker has significant dental co-morbidities that require clearance prior to joint replacement surgery. Therefore, this request is not medically necessary.

Assistant Surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physician Fee Schedule Centers for Medicare and Medicaid services: <http://www.cms.gov/>

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Lovenox 30mg, #28 injections: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Jobin S, Kalliainen L, Adebayo L, Agarwal Z, Card R, Christie B, Haland T, Hartmark M, Johnson P, Kang M, Lindvall B, Mohsin S, Morton C. Venous thromboembolism prophylaxis. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2012 Nov. 51 p

Decision rationale: Based on the National Guideline Clearinghouse Venous thromboembolism prophylaxis guidelines, neuraxial blockade in workers receiving prophylactic antithrombotic therapy include enoxaparin (Lovenox). The prophylactic dose for a single-daily dosing is as follows: Insertion: At least 12 hours after the last dose. Subsequent dose at least 4 hours after catheter insertion Removal: At least 12 hours after the last dose. Subsequent dose at least 4 hours after catheter removal The prophylactic dose for a twice-daily dosing is as follows: Insertion: Epidural catheter not recommended Removal: May initiate twice-daily dosing at least 4 hours after catheter removal As the surgical request is not supported, this request for Lovenox is not medically necessary.

Oxycodone 10mg, #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Oxycodone Page(s): 76-80, 97.

Decision rationale: Per the MTUS Chronic Pain Medical Treatment Guidelines, Oxycodone is a potentially addictive opioid analgesic medication, and it is a Schedule II controlled substance. As the surgical request is not supported, this request for Oxycodone is not medically necessary.

OxyContin 10mg #20 tabs: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, OxyContin Page(s): 76-80, 97.

Decision rationale: Per the MTUS Chronic Pain Medical Treatment Guidelines, OxyContin is the brand name of a time-release formula of the analgesic chemical oxycodone, produced by the pharmaceutical company Purdue Pharma. This drug was recently included in a list of 20 medications identified by the Food and Drug Administration's Adverse Event Reporting System that are under Food and Drug Administration investigation. Oxycodone is a potentially addictive opioid analgesic medication, and it is a Schedule II controlled substance. As the surgical request is not supported, this request for OxyContin is not medically necessary.

Postoperative physical therapy for 12 visits: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: Per the Chronic Pain Medical Treatment Guidelines, post-surgical treatment for arthroplasty of the knee includes 24 visits over 10 weeks. As the surgical request is not supported, this request for postoperative physical therapy for 12 visits is also not medically necessary.

Cold therapy unit for 14 days: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), Continuous-flow cryotherapy

Decision rationale: Per Official Disability Guidelines, a cold therapy unit is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. As the surgical request is not supported, this request for a cold therapy unit for 14 days is not medically necessary.

Continuous passive motion (CPM) unit for 21 days: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), Continuous passive motion (CPM)

Decision rationale: Per Official Disability Guidelines, a continuous passive motion unit is recommended as indicated below, for in-hospital use, or for home use in workers at risk of a stiff knee, based on demonstrated compliance and measured improvements, but the beneficial effects over regular physical therapy may be small. Routine home use of continuous passive motion has minimal benefit. Although research suggests that continuous passive motion should be implemented in the first rehabilitation phase after surgery, there is substantial debate about the duration of each session and the total period of continuous passive motion application. As the

surgical request is not supported, this request for continuous passive motion is also not medically necessary.

Walker: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), Walking aids (canes, crutches, braces, orthoses, & walkers)

Decision rationale: Per Official Disability Guidelines, a walker is recommended, as indicated below. Almost half of workers with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. As the surgical request is not supported, this request for a walker is not medically necessary.

Raised toilet seat: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), Durable medical equipment (DME)

Decision rationale: Per Official Disability Guidelines, a raised toilet seat is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment below. Most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used for convenience in the home. As the surgical request is not supported, this request for a raised toilet seat is not medically necessary.

Three (3) day hospital stay: 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.