

Case Number:	CM14-0030691		
Date Assigned:	06/20/2014	Date of Injury:	05/16/1998
Decision Date:	08/06/2014	UR Denial Date:	02/26/2014
Priority:	Standard	Application Received:	03/10/2014

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 Surgeon, 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:

██████████ is a 63-year-old female who reported injury on 05/16/1998. The mechanism of injury was a motor vehicle accident. The injured worker was status post tibia intramedullary rod placement in 1998, status post hardware and status post left knee partial medial meniscectomy on 12/28/2000. The documentation of 01/22/2014 revealed the injured worker had pain with twisting, prolonged standing, and prolonged sitting and upon rising into a standing position from sitting since the surgical interventions. The injured worker additionally indicated it was difficult to stand and weight bear on the knee and straighten the knee with kneeling intermittently. The injured worker had pain in the right anterior medial joint line area with positive pillow sign. It was indicated the knee did not lock; however, it did catch and felt unstable. The injured worker underwent an x-ray on the same date of service which revealed a bone cyst in the subchondral aspect of the posterior medial portion of the medial tibial plateau. The injured worker had 7 degrees valgus knee on full extension and full weight bearing. The diagnosis included persistent complaints of intra-articular pain which never went away after the knee was scoped 13 years prior. Rule out meniscus tear. The treatment plan included an MRI for the left knee and a followup as well as an intra-articular injection and possible surgical intervention. The injured worker underwent an MRI of the left knee without contrast on 02/06/2014 which revealed considerable metal artifact anteriorly in the proximal tibia, a large cystic area in the medial tibia where there is joint space narrowing and degenerative changes more pronounced than in the other part of the knee; there were bony osteophytes in all compartments; there is a probable radial tear in the mid portion of the lateral meniscus with complete tears in the posterior mid portion of the medial meniscus and there was no subluxation of the patella within the patellar retinacula. The documentation of 02/18/2014 revealed the injured worker had tenderness to palpation not only in the medial joint line but also in the medial tibial plateau and medial femoral

condyle. The documentation indicated at times when the injured worker was on her feet and frequently on uneven ground, the knee pain was significant enough that it was difficult to continue her job. The treatment recommendation was for a cortisone injection. The treatment plan included the physician opined an arthroscopic surgery would not take care of the problem. As such, the treatment recommendation was a total knee arthroplasty. The request for authorization included a left knee arthroplasty, postoperative medications, postoperative in-home physical therapy and outpatient physical therapy, as well as a cortisone injection into the left knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Total Left Knee Arthroplasty: 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), Indications for Surgery - Knee Arthroplasty.

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 Chapter, Knee Joint Replacement.

Decision rationale: The Official Disability Guidelines recommend knee arthroplasty, joint replacement for treatment if 2 of the 3 compartments are affected. There should be documentation of exercise therapy and medication failure plus documentation of limited range of motion less than 90 degrees for total knee replacement and nighttime joint pain and no relief with conservative care and documentation of current functional limitations demonstrating the necessity for intervention. There should be documentation the injured worker is over 50 years of age and has a body mass index of less than 35. There should be documentation of osteoarthritis on standing x-rays or previous arthroscopy documenting advanced chondral erosion or exposed bone. The clinical documentation submitted for review indicated the injured worker was over 50 years of age and had positive findings upon MRI. However, there was lack of documentation of exercise therapy and medication failure, limited range of motion of less than 90 degrees, nighttime joint pain, no pain relief with conservative care, and documentation of current functional limitations demonstrating the necessity for intervention. There was a lack of documentation of a body mass index less than 35. Given the above, the request for a total left knee arthroplasty is not medically necessary.

Post Operative Physical Therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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.

Post-Operative Percocet 10/325mg #40: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 47, 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

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.

Post Operative Norco 10/325mg #40: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 47, 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

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.

Post Operative In-Home Physical Therapy 3 x week for 2 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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.