

Case Number:	CM14-0031458		
Date Assigned:	04/09/2014	Date of Injury:	03/20/2013
Decision Date:	05/28/2014	UR Denial Date:	01/07/2014
Priority:	Standard	Application Received:	02/03/2014

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:

The injured worker is a 57-year-old male who reported an injury on 06/30/2008. The mechanism of injury was lifting and twisting. The injured worker's initial course of treatment is unclear. The injured worker is noted to have complaints of lower back pain, headaches, sexual dysfunction, right hip and knee pain, and insomnia. The injured worker received prior courses of physical therapy, which reportedly provided him with no benefit; however, he states that performance of a home exercise program does provide him with moderate relief. The injured worker also received facet joint injections, radiofrequency ablations, epidural steroid injections, and 2 lumbar laminectomies (surgery was prior to the most recent injury of 06/2008). The injured worker reports that the epidural steroid injections did not provide him with long-term pain relief, and no discussion was provided regarding the effect of the facet joint injections or radiofrequency procedures. The injured worker has been managed under a chronic pain specialist and reports progression of lower back pain over time; however, the injured worker denies any neurological symptoms, including numbness, incontinence, saddle anesthesia, or foot drop. The most recent physical examination was focused on the lumbar spine and revealed flexion of 44 degrees, limited by pain; extension of 18 degrees, limited by pain; right lateral bending of 15 degrees; and left lateral bending of 10 degrees. The injured worker exhibited a normal heel and toe walk, positive lumbar facet loading, 4/5 muscle strength in the right lower extremity, and intact sensation and reflexes throughout. There were no physical examinations performed that included a focused assessment of the bilateral knees, and there were also no subjective complaints regarding this body region. It was noted that the injured worker was recently prescribed with a course of 7 sessions of physical therapy; however, there was no discussion regarding its effects.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY PRE-HAB X 4 VISITS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines recommend up to 10 visits of physical therapy to treat an unspecified myalgia or myositis, after an initial 6 visits have been determined effective. The clinical information submitted for review provided evidence that the injured worker has received a recent course of 7 sessions of physical therapy; however, no physical therapy notes were submitted for review, and no discussion was contained within the medical records reviewed, regarding the injured worker's progress or benefit received to date. In addition, the current request does not specify which body region is to be treated. Additionally, the range of motion values for the lumbar spine provided in the clinical notes indicate that the injured worker had flexion of 40 degrees, extension of 15 degrees, right lateral bending of 15 degrees, and left lateral bending of 10 degrees on 01/16/2014. Follow-up measurements include 44 degrees of flexion, 18 degrees of extension, and unchanged right lateral bending on 03/13/2014. After 7 sessions of physical therapy, this does not provide evidence of significant improvement; furthermore, there were no pain levels provided for review. Without information regarding the body region to be treated, and therapy notes indicating the injured worker's progress, additional therapy is not indicated. The request for physical therapy pre-rehabilitation, four visits is not medically necessary and appropriate.

LEFT TOTAL 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 (ODG).

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, KNEE JOINT REPLACEMENT

Decision rationale: The California MTUS/ACOEM Guidelines do not specifically address the need for a knee replacement; therefore, the Official Disability Guidelines (ODG) was supplemented. ODG indicates that total knee replacements may be appropriate for patients exhibiting certain symptoms. Objective clinical findings should include patients over the age of 50, a body mass index of less than 35, range of motion of the knee limited to less than 90 degrees, nighttime joint pain, no relief with conservative care, and documentation of functional limitations. Furthermore, there was no inclusion of any imaging findings documenting significant loss of a chondral clear space in at least 1 of the 3 compartments, a varus or valgus deformity, and/or evidence of a previous arthroscopy documenting chondral erosion. Additionally, there were no physical examinations performed focused on the bilateral knees, no range of motion measurements obtained providing evidence of less than 90 degrees of functional

motion, and no evidence that a course of physical therapy or injections have been tried and failed. Without any evidence suggesting knee complaints or functional disability, medical necessity for this request has not been established. The request for left total knee replacement is not medically necessary and appropriate.

RIGHT TOTAL 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 (ODG)

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, KNEE JOINT REPLACEMENT

Decision rationale: The California MTUS/ACOEM Guidelines do not specifically address the need for a knee replacement; therefore, the Official Disability Guidelines (ODG) was supplemented. ODG indicates that total knee replacements may be appropriate for patients exhibiting certain symptoms. Objective clinical findings include patients over the age of 50, a body mass index of less than 35, range of motion of the knee limited to less than 90 degrees, nighttime joint pain, no relief with conservative care, and documentation of functional limitations. Furthermore, there was no inclusion of any imaging findings documenting significant loss of a chondral clear space in at least 1 of the 3 compartments, a varus or valgus deformity, evidence of a previous arthroscopy documenting chondral erosion. Additionally, there were no physical examinations performed focused on the bilateral knees, no range of motion measurements obtained providing evidence of less than 90 degrees of functional motion, and no evidence that a course of physical therapy or injections have been tried and failed. Without any evidence suggesting knee complaints or functional disability, medical necessity for this request has not been established. The request for a total right knee replacement is not medically necessary and appropriate.

HOSPITAL STAY X 2 DAYS: 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 CLEARANCE BY CARDIOLOGIST: 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.