

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0033961 | | |
| Date Assigned: | 06/20/2014 | Date of Injury: | 01/29/2009 |
| Decision Date: | 07/24/2014 | UR Denial Date: | 02/20/2014 |
| Priority: | Standard | Application Received: | 03/18/2014 |

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 patient is a 50-year-old male who was injured on 1/29/2009, while climbing down a ladder his right knee popped. The patient underwent arthroscopy with partial medial meniscectomy, partial lateral meniscectomy and chondroplasty in 2009, right total knee arthroplasty in 6/2013, and revision TKR with polyethylene exchange on 11/11/2013. A prior UR determination was performed at only 2/20/2014 wherein determination was provided to modify the request for right knee arthroscopy and debridement of the wound, to certify wound debridement, and non certify arthroscopy. The reviewer noted that the patient was described as having a 2.5 to 3 inch of the previous article surgical wound dehiscence with possible security action. There is no documentation to indicate there was any intrinsic articular pathology to warrant knee arthroscopy. A determination was also provided to modify the request for preoperative clearance with internal medicine, to certify preoperative labs CBC with differential, CMP, PT/PTT. The reviewer noted that the patient was only three months post general anesthesia for total knee arthroplasty revision, and there was no documentation of a change in the patient's individual medical condition that would warrant preoperative medical clearance with internal medicine. The requested postop PT was certified. According to the primary treating physician's progress report dated 2/11/2014, the patient was doing well status post polyethylene exchange. He reported that while at a wedding, he had fallen directly on his post-surgical right knee and had developed a very superficial opening at the distal wound, basically closed. On examination, he had complete extension, 120 degrees flexion, no effusion, no calf pain. There was some reactive subcutaneous tissue with some raised areas, a 2.5 to 3 inch raised area of the wound that appeared to be a suture reaction. There was no redness and no drainage. The patient was given Cipro, and recommendation was for follow-up in 1 week, if still symptomatic with reactive sutures, would recommend debridement of wound as an outpatient with elliptical excision of the reactive suture.

Medical evaluation for pre-operative clearance was performed on 3/25/2014. Patient denies any medical problems. He is to undergo debridement due to having some drainage from right knee incision site. Patient has no other medical complaints. Assessment was status post TKR. To re-check BP was 120/88, EKG looked okay, pending labs, patient appeared stable to proceed with the procedure. The primary treating physician's progress report dated 3/25/2014 states physical examination is without change. Still a suture reaction at distal portion of wound, no swelling, no redness, and no calf tenderness. Impression: Suture reaction status post total knee revision. Operative report dated 3/31/2014 documents the patient underwent scar revision of the right knee. Pre op and post-op diagnosis: Inflammation superficial wound, status-post total right knee replacement. The procedure revealed the skin had, very superficially, some areas of breakdown, no areas of redness or fever. There was no intra-articular effusion. The knee had complete extension and 125 degrees flexion with good stability. The incision had some areas of subcuticular suture reaction and this area was entirely ellipsed, the subcuticular tissue was then aggressively debrided. The area was irrigated with bacitracin and closed. The primary treating physician's progress report dated 6/5/2014 documents the patient presents with complaints of still having some ache and some weakness going upstairs. He denies fevers or night sweats. Physical examination documents complete extension, flexion 125, AP drawer trace to 1+, good varus-valgus stability, and no calf tenderness. Diagnosis is right knee pain post total knee replacement. Treatment plan TTD for 2 months and Celebrex twice daily with meals.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right knee arthroscopy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines Knee and Leg Chapter, Diagnostic arthroscopy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 334. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Diagnostic Arthroscopy.

Decision rationale: According to the medical records, the patient was doing well status post right knee revision total arthroplasty in 11/2013, when he sustained a fall on the knee in 2/2014, and developed a superficial wound with suspected suture reaction. Subsequent follow-up examinations continued to support that assessment. The medical records do not reveal any indication of any pathology of the joint to warrant arthroscopy. The medical necessity of a right knee arthroscopy is not established. Therefore is not medically necessary.

Pre-operative clearance with Internal Medicine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (Official Disability Guidelines, Pre-operative lab testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Pre-operative testing, general.

Decision rationale: According to the Official Disability Guidelines, Preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, and urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Based on the medical records provided, the patient is recommended to proceed with debridement of the right knee wound and suture reaction. The patient would undergo a simple outpatient procedure. There is no indication in the records that significant change or relevant medical condition exists now that was not revealed at the time of his prior preoperative assessment that was done for the knee revision procedure in 11/2013. Given the recommended debridement procedure, standard preoperative evaluation and labs to assess for potential infection would be medically indicated, however internal medicine consultation is not. Therefore request is not medically necessary.