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| Case Number: | CM14-0034102 | | |
| Date Assigned: | 07/23/2014 | Date of Injury: | 04/24/2003 |
| Decision Date: | 08/27/2014 | UR Denial Date: | 03/10/2014 |
| 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 Orthopaedic 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 63-year-old male residential energy technician sustained an industrial injury on 4/24/03. The mechanism of injury was not documented. Past medical history was positive for diabetes and hypertension. The 9/13/03 left knee MRI showed degenerative medial meniscus tear with chondromalacia and osteoarthritis of the medial compartment, minor lateral meniscus degeneration, joint effusion, and probable ruptured popliteal cyst. The records indicated that the patient had recently been managed with corticosteroid and hyaluronic acid injections. The 2/17/14 treating physician report indicated that the patient reported a long history of bilateral knee pain. The patient had relocated from [REDACTED] and wanted to have his knees addressed. The patient took Tramadol and had done physical therapy and injections. Physical exam documented normal lower extremity strength, varus alignment, and small effusions. The knees were reported to be stable. X-rays showed near bone-on-bone changes in the medial compartments. The impression was bilateral knee osteoarthritis, probably posttraumatic. The treatment plan recommended bilateral total knee replacements. The 3/10/14 utilization review denied the request for left total knee replacement and associated items/services, based on documentation of unicompartmental disease, lack of a radiologist report, lack of body mass index, no details of conservative treatment, and a benign exam. A 4/7/14 prescription for physical therapy for the bilateral knees 2-3 times per week for 8 weeks was noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Total Knee Athroplasty: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 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 and Leg, Knee joint replacement.

Decision rationale: The California MTUS does not provide recommendations for total knee arthroplasty. The Official Disability Guidelines recommend total knee replacement when surgical indications are met. If only 1 compartment is affected, a unicompartmental or partial replacement may be considered. If 2 of the 3 compartments are affected, a total joint replacement is indicated. Guideline criteria for knee joint replacement include exercise and medications or injections, limited range of motion (< 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 (BMI) less than 35, and imaging findings of osteoarthritis. There is no documentation of limited range of motion, night-time joint pain, or body mass index. There is documentation of significant medial compartment osteoarthritis. There is no evidence of patellofemoral or lateral compartment disease which is required to support the medical necessity of a total knee replacement. The guideline criterion has not been met. Therefore, this request for left total knee arthroplasty is not medically necessary.

Lab., (Unspecified): 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 Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38.

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

LOS (Length Of Stay) x3: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines hospital length of stay.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Hospital length of stay (LOS).

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

Inpatient Rehab (Begins in-Hospital and continues for three months approximate): 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 and Leg, Skilled nursing facility (SNF) care.

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

Walker: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines walkers.

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

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

Possible Ice Machine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Continuous flow Cryotherapy.

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

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

Cane: 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 and Leg, Walking aids (canes, crutches, braces, orthoses, & walkers).

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

Home health for 2 weeks: 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 HOME HEALTH SERVICES Page(s): 51.

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