MAXIMUS Federal Services

Case Number:	CM14-0044011		
Date Assigned:	06/16/2014	Date of Injury:	11/17/2012
Decision Date:	07/30/2014	UR Denial Date:	02/26/2014
Priority:	Standard	Application Received:	03/07/2014

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:

The injured worker is a 65-year-old female who reported an injury on 11/17/2012. The injured worker underwent an x-ray of the right knee 4 views on 01/07/2014, which revealed mild to moderate degenerative changes most pronounced in the medial compartment. The injured worker underwent an MRI of the right knee on 01/22/2014, which revealed a horizontal oblique tear and free edge blooming through the body and posterior horn of the medial meniscus with extension to the posterior root. There was a 6 mm medial meniscal extrusion. There was intrasubstance degeneration of the posterior horn of the lateral meniscus. There was high-grade chondrosis of the medial and patellofemoral compartments of the knee. There were medial and small lateral compartment osteophytes. There was degeneration of the deep fibers of the medial collateral ligament and there was a moderate sized effusion, which extended into a large popliteal cyst. The documentation of 02/20/2014 revealed the injured worker had severe knee pain. The injured worker indicated she had locking in the knee and could not walk. The physical examination revealed the injured worker had 0 to 100 degrees of movement with mild effusion. The injured worker had a negative posterior drawer examination and normal valgus laxity along with normal varus laxity. The x-ray of the right knee revealed end stage arthritis with joint space narrowing. The diagnosis included primary localized osteoarthritis lower leg. The treatment plan included a total knee arthroplasty with an assistant surgeon, cold therapy unit, and CPM rental. The request additionally was made for 24 sessions of postoperative physical therapy. The injured worker had conservative care including steroid injections, NSAIDs, and physical therapy with x-rays showing evidence of end stage arthritis.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT TOTAL KNEE ARTHROPLASTY.: 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 Chapter, Knee Joint Replacement.

Decision rationale: The Official Disability Guidelines indicate that knee joint replacement is appropriate if 2 or 3 of the compartments are affected. There should be documentation of exercise therapy and medications failing as well as limited range of motion of less than 90 degrees for a total knee replacement and nighttime joint pain and no pain relief with conservative care and documentation of current functional limitations demonstrating a necessity of intervention as well as over 50 years of age and a body mass index of less than 35 and standing x-rays which reveal significant loss of chondral clear space in at least 1 of the 3 compartments. The clinical documentation submitted for review indicated the injured worker had failed exercise therapy and medications. However, there was a lack of documentation of limited range of motion of < 90 degrees and nighttime joint pain as well as documentation of current functional limitations. There was a lack of documentation of the injured worker's body mass index. Given the above, the request for RIGHT TOTAL KNEE ARTHROPLASTY is not medically necessary.

3 DAY INPATIENT STAY AT HOSPITAL: 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.

ASSISTANT SURGEON PHYSICIAN ASSISTANT: 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.

PREOPERATIVE CLEARANCE IN HOUSE: 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.

CPM (CONTINUOUS PASSIVE MOTION) FOR 17 DAY RENTAL: 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.

CTU (COLD THERAPY UNIT) FOR 7 DAY RENTAL: 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.

WALKER: 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.

24 POST OPERATIVE PHYSICAL THERAPY SESSIONS: 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.