

Case Number:	CM14-0051080		
Date Assigned:	07/07/2014	Date of Injury:	01/07/2009
Decision Date:	08/28/2014	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	04/18/2014

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 Pennsylvania. 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 52-year-old male who sustained a vocational injury on January 7, 2009. The medical records provided for review states that the injured worker subsequently underwent right knee diagnostic and operative arthroscopy on June 10, 2011. The report of the office visit dated June 26, 2014 noted persistent pain since his surgery in 2011. Conservative treatment was documented to include Norco, Aleve, Synvisc injections, multiple steroid injections, an unloader brace and physical therapy. Physical examination revealed a minimally antalgic gait, tenderness along the medial joint line, full active extension and flexion to 120 degrees, and no instability seen. The report of x-rays showed well maintained joint spaces throughout in a tricompartmental fashion. The physician documented his impression as pain out of proportion to physical findings similarly localized to the medial aspect of the knee with well-maintained joint spaces. The physician documented that he did not feel the claimant was a candidate for arthroplastic surgery as his joint spaces were normal. This review is for unicompartmental knee arthroplasty versus total right knee arthroplasty under general anesthesia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Unicompartmental knee arthroplasty vs total right knee arthroplasty under general anesthesia: 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 and Leg Chapter, Knee Joint Replacement.

Decision rationale: Total hip and total knee arthroplasties are well accepted as reliable and suitable surgical procedures to return patients to function. The most common diagnosis is osteoarthritis. Overall, total knee arthroplasties were found to be quite effective in terms of improvement in health-related quality-of-life dimensions, with the occasional exception of the social dimension. Age was not found to be an obstacle to effective surgery, and men seemed to benefit more from the intervention than did women. Total knee arthroplasty was found to be associated with substantial functional improvement. Navigated knee replacement provides few advantages over conventional surgery on the basis of radiographic end points. The majority of patients who undergo total joint replacement are able to maintain a moderate level of physical activity, and some maintain very high activity levels. Functional exercises after hospital discharge for total knee arthroplasty result in a small to moderate short-term, but not long-term, benefit. In the short term physical therapy interventions with exercises based on functional activities may be more effective after total knee arthroplasty than traditional exercise programs, which concentrate on isometric muscle exercises and exercises to increase range of motion in the joint. Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense physical therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. In this RCT, perioperative celecoxib (Celebrex) significantly improved postoperative resting pain scores at 48 and 72 hrs, opioid consumption, and active range of motion (ROM) in the first three days after total knee arthroplasty, without increasing the risks of bleeding. The study group received a single 400 mg dose of celecoxib, one hour before surgery, and 200 mg of celecoxib every 12 hours for five days. Total knee arthroplasty (TKA) not only improves knee mobility in older patients with severe osteoarthritis of the knee, it actually improves the overall level of physical functioning. Levels of physical impairment were assessed with three tools; the Nagi Disability Scale, the Instrumental Activities of Daily Living Scale (IADL) and the Activities of Daily Living (ADL) Scale. Tasks on the Nagi Disability Scale involve the highest level of physical functioning, the IADL at intermediate level, and the ADL Scale involves the most basic levels. Statistically significant average treatment effects for TKA were observed for one or more tasks for each measure of physical functioning. The improvements after TKA were sizeable on all three scales, while the no-treatment group showed declining levels of physical functioning. This study showed that total knee replacement is the second the most successful orthopaedic procedure for relieving chronic pain, after total hip. The study compared the gains in quality of life achieved by total hip replacement, total knee replacement, surgery for spinal stenosis, disc excision for lumbar disc herniation, and arthrodesis for chronic low back pain. Hip replacement reduced pain to levels normal for age, reduced physical functioning to within 75% normal levels, and restored quality of life to virtually normal levels. Total knee replacement was the next most successful procedure, and it all but eliminated pain, improved physical functioning to 60% normal, and restored quality of life to within 65% of normal. A 6-week program of progressive strength training targeting the quadriceps femoris muscle group substantially improves strength and function following total knee arthroplasty for treatment of osteoarthritis, compare. The MTUS and ACOEM Guidelines do not address this request. The most recent office note

available for review from June 26, 2014 was very specific in the plan of care by the physician documenting that the claimant had well maintained joint spaces of the right knee, and appeared to have pain out of proportion to exam and given the fact that he was a young, active gentleman he was not a candidate for total knee arthroplasty. The X-ray report identifies well maintained joint spaces in the knee. Therefore, the request for a right total knee arthroplasty or unicompartment arthroplasty of the right knee is not medically necessary at this time.

Assistant surgeon: 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.

Inpatient hospital stay: 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-op medical clearance: 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.

Post-op physical therapy 12 sessions, two (2) times a week for six (6) weeks: 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.

