

Case Number:	CM14-0087123		
Date Assigned:	07/23/2014	Date of Injury:	02/14/2008
Decision Date:	08/27/2014	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	06/10/2014

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 55-year-old male who reported an injury on 02/14/2008 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to his left knee. The injured worker's treatment history included arthroscopic surgery in 2008, nonsteroidal anti-inflammatory drugs, a knee brace, physical therapy, corticosteroid injections and viscosupplementation injections. The injured worker underwent an x-ray on 05/02/2014 that documented that there was degenerative narrowing in the medial joint space with medial tibial spur formation; however, an otherwise normal knee. It was noted that there were no significant changes from the MRI scan on 02/28/2009. The injured worker was evaluated on 05/02/2014. It was documented that the injured worker had moderate to severe right knee pain complaints. Physical findings included mild right knee swelling with moderate varus deformity with range of motion described as 0 degrees in extension to 120 degrees in flexion. The injured worker's diagnoses included severe osteoarthritic changes of the right knee. A total knee arthroplasty was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Total Knee Replacement Inpatient: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 343-344.
Decision based on Non-MTUS Citation Official Disability Guidelines, <http://www.odg->

twc.com/odgtwc/knee.htm - Knee Joint Replacement; Indications for 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 chapter, Knee Joint Replacement.

Decision rationale: The California Medical Treatment Utilization Schedule does not specifically address this surgical intervention. The Official Disability Guidelines recommend a total knee replacement for injured workers with significantly restricted physical findings with evidence of significant tricompartmental osteoarthritis on an imaging study. The clinical documentation submitted for review does not indicate that the injured worker has severely limited range of motion indicative of severe endstage osteoarthritis. The injured worker's range of motion is from 0 to 120 degrees. The Official Disability Guidelines recommend restricted range of motion described as 0 to 90 degrees to support this type of surgical intervention. Additionally, the independent x-ray report dated 05/02/2014 documented joint space changes in 1 compartment without significant progression from a 2009 MRI. Therefore, the need for a total knee replacement would not be indicated in this clinical situation. As such, the requested right total knee replacement (inpatient) is not medically necessary or appropriate.

CPM Machine Rental for 3 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, <http://www.odg-twc.com/odgtwc/knee.htm> - CPM use for the knee, Criteria for the use of continuous passive motion devices.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation and is not medically necessary, the requested ancillary service is also not medically necessary.

Post Operative Physical Therapy three (3) times a week for six (6) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation and is not medically necessary, the requested ancillary service is also not medically necessary.

3 in 1 Bedside Commode: 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: As the requested surgical intervention is not supported by the documentation and is not medically necessary, the requested ancillary service is also not medically necessary.

Front wheeled 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, <http://www.odgtwc.com/odgtwc/knee.htm> - Walking aids.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation and is not medically necessary, the requested ancillary service is also not medically necessary.