

<b>Case Number:</b>	CM14-0176077		
<b>Date Assigned:</b>	10/29/2014	<b>Date of Injury:</b>	08/14/2012
<b>Decision Date:</b>	03/26/2015	<b>UR Denial Date:</b>	09/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 56 year old injured male worker suffered and industrial injury on 8/14/2012. The diagnoses were right knee degenerative joint disease and right knee internal derangement. The diagnostic was standing s-rays of right knee. The treatments were right knee surgery and medications. The treating provider reported the knee to have "bone on bone" with pain level of 3/10. The exam revealed tenderness of the right knee, restricted range of motion with crepitus and impaired gait. Exam note from 9/10/14 demonstrates bone on bone of the right knee but no formal report is attached. Body mass index is noted of 31.4 per exam notes. The Utilization Review Determination on 9/23/2014 non-certified:1. Right total knee replacement, citing ACOEM chapter and Official Disability Guidelines, knee, and leg chapter2. Voltaren Gel 100GM #5 tubes, citing MTUS Chronic Pain Treatment Guidelines, topical analgesics3. Spanish Interpreter, citing National Institutes of Health.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Total Knee Replacement Surgery: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg, Knee arthroplasty

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of total knee replacement. According to the Official Disability Guidelines regarding Knee arthroplasty: Criteria for knee joint replacement which includes conservative care with subjective findings including limited range of motion less than 90 degrees. In addition, the patient should have a BMI of less than 35 and be older than 50 years of age. There must also be findings on standing radiographs of significant loss of chondral clear space. The clinical information submitted demonstrates insufficient evidence to support a knee arthroplasty in this patient. There is no documentation from the exam notes from 9/10/14 of increased pain with initiation of activity or weight bearing. There are no records in the chart documenting when physical therapy began or how many visits were attempted. There is no evidence in the cited examination notes of limited range of motion less than 90 degrees. There is no formal weight bearing radiographic report of degree of osteoarthritis. Therefore, the guideline criteria have not been met and the determination is for non-certification.

**Voltaren gel 100g #5 tubes:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter Voltaren Gel (diclofenac)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Voltaren gel Page(s): 111-112.

**Decision rationale:** CA MTUS/Chronic Pain Medical Treatment Guidelines, page 111-112, NSAIDs, states that Voltaren Gel is, Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip, or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). In this case, there is insufficient evidence of osteoarthritis in the records from 9/10/14 to warrant Voltaren Gel. Therefore, determination is for non-certification.

**Spanish translator for all office visits and procedures:** 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.