MAXIMUS Federal Services

Case Number:	CM14-0195621		
Date Assigned:	12/03/2014	Date of Injury:	12/17/2002
Decision Date:	01/26/2015	UR Denial Date:	11/07/2014
Priority:	Standard	Application Received:	11/21/2014

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 56 year old male claimant with an industrial injury dated 12/17/02. The patient is status post three knee surgeries with the most recent done a year ago. MRI of the left knee dated 04/25/13 reveals a large osteochondral lesion in the posterior weight-bearing medial femoral condyle measuring 18 x 20 x 12mm with foci of full-thickness or near full-thickness chondral erosion along the margins of the lesion. It is noted that there was no edema or fluid undermining the lesion, but there was evidence of mild patellofemoral arthrosis with post-operative change Hoffa's fat pad along the inferior margin of the patella. Exam note 09/09/14 states the patient returns with left knee pain and locking. Bone scan dated 10/30/14 reveals increased activity along the left hemi-prosthesis more tibial than femoral consistent with loosening. Exam note 10/30/14 the patient continues to have knee pain. Diagnosis is noted as degenerative joint disease of the left knee. Treatment includes a convert loose left medial unicompartmental prosthesis to total knee replacement.56 year old male claimant with an industrial injury dated 12/17/02. The patient is status post three knee surgeries with the most recent done a year ago. MRI of the left knee dated 04/25/13 reveals a large osteochondral lesion in the posterior weight-bearing medial femoral condyle measuring 18 x 20 x 12mm with foci of full-thickness or near full-thickness chondral erosion along the margins of the lesion. It is noted that there was no edema or fluid undermining the lesion, but there was evidence of mild patellofemoral arthrosis with post-operative change Hoffa's fat pad along the inferior margin of the patella. Exam note 09/09/14 states the patient returns with left knee pain and locking. Bone scan dated 10/30/14 reveals increased activity along the left hemi-prosthesis more tibial than femoral consistent with loosening. Exam note 10/30/14 the patient continues to have knee pain. Diagnosis is noted as degenerative joint disease of the left knee. Treatment includes a convert loose left medial unicompartmental prosthesis to total knee replacement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Assistant Surgeon convert loose left medial unicompartmental prosthesis to total knee replacement: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Knee and Leg chapter- Knee joint replacement, www.ncbi.nim.nih.gov/pubmed/24563977

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: 1. http://www.aaos.org/about/papers/position/1120.asp

Decision rationale: CA MTUS/ACOEM/ODG are silent on the issue of assistant surgeon. According to the American College of Surgeons: "The first assistant to the surgeon during a surgical operation should be a trained individual capable of participating and actively assisting the surgeon to establish a good working team. The first assistant provides aid in exposure, hemostasis, and other technical function, which will help the surgeon carry out a safe operation and optimal results for the patient. The role will vary considerably with the surgical operation, specialty area, and type of hospital." There is an indication for an assistant surgeon for a revision total joint procedure. The guidelines state that "the more complex or risky the operation, the more highly trained the first assistant should be." In this case the decision for an assistant surgeon is not medically necessary.This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.