

<b>Case Number:</b>	CM14-0198223		
<b>Date Assigned:</b>	12/08/2014	<b>Date of Injury:</b>	11/12/2002
<b>Decision Date:</b>	02/04/2015	<b>UR Denial Date:</b>	11/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2014

### 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 Minnesota. 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 45-year-old female with a date of injury of 11/12/2002. Per progress notes she has bilateral unicompartmental knee arthroplasties. She also has a spinal cord stimulator for chronic low back pain. Per December 3, 2014 follow-up report her low back pain radiates to both lower extremities and she has pain in both knees. She ambulates with a 4-point cane. Well-healed incisions are noted. She has pain in both knees with flexion and extension against gravity. The reason for the revision of the left unicompartmental knee arthroplasty is not given. Per encounter date of 12/10/2014 she has pain radiating from the lumbar region down the left lower extremity to the foot. The pain is described as sharp. The knee is said to be burning. A detailed physical examination of the left knee is not available. The only physical finding documented is pain with range of motion. Per encounter date of December 3, 2014 she has pain in the lower back with radiation to the left lower extremity described as sharp and stabbing. The pain radiated down the left leg to the plantar area with tingling. It was rated 7/10. The patient reported worsening of the low back pain with neuropathy. Documentation from July 30, 2014 indicates that she was scheduled for a left unicompartmental knee arthroplasty on November 11, 2013. An operative report dated November 11, 2013 confirms the operative procedure consisting of a left unicompartmental arthroplasty utilizing a Smith and nephew journey prosthesis. A postoperative progress note dated January 1, 2014 indicated that the left knee pain had diminished significantly. A subsequent report dated January 27, 2014 indicated that the patient continued to have pain and a hot sensation just above her kneecap. Radiology reports pertaining to the unicompartmental arthroplasty are not submitted. However, per documentation of July 30, 2014 both knees had flexion beyond 90 in the sitting position and she was able to extend the knees completely. There was no instability. X-rays of both knees were obtained and

there were well performed bilateral medial joint replacements noted. There was no documentation of loosening, infection, or any other complication.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Revision of Left Total Knee Arthroplasty: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines- Treatment for Workers' Compensation, Online Edition Knee and Leg Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Knee, topic: Revision knee replacement; total knee replacement.

**Decision rationale:** California MTUS guidelines do not address this topic. ODG guidelines are therefore used. Revision total knee arthroplasty is recommended if there is failure of the originally approved arthroplasty. The injured worker has a chronic pain syndrome with failed laminectomy and low back pain with radiation down both lower extremities. She has a spinal cord stimulator. She has sharp pain going down the left leg to the foot with paresthesias on the plantar aspect of the foot. She has burning in the leg. She underwent a unicompartmental arthroplasty for the medial compartment in November 2013. There is no documented evidence of loosening, infection, or mechanical failure of the implant. There is no worsening of the osteoarthritis in the lateral compartment or the patellofemoral joint reported. ODG criteria for a knee arthroplasty include imaging evidence of osteoarthritis on a standing x-ray documenting significant loss of the joint space with valgus or valgus deformity. There is no radiographic evidence of loosening or failure of the implant. Based upon the above, the criteria for a revision total knee arthroplasty have not been met and as such, the request for a revision arthroplasty is not supported and the medical necessity is not substantiated.

#### **CBC, CMP, PT/PTT: 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 Urinalysis: 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 Chest X-ray:** 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 EKG:** 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.

**Knee Immobilizer Purchase:** 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 Machine 21 days 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.

**Cold Therapy Unit Purchase:** 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 Inpatient Skilled Nursing Facility 5-7 days:** 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 3x week x 4 weeks left knee:** 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.