

Case Number:	CM14-0198441		
Date Assigned:	12/08/2014	Date of Injury:	03/07/2008
Decision Date:	02/04/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	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, has a subspecialty in Sports Medicine 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:

This injured worker is a 55-year-old male with a date of injury 03/07/2008 and the mechanism of injury was when he stood up his right knee popped. His diagnoses included status post knee meniscectomy, fracture of the tibial plateau and end stage degenerative disc disease. His past treatments included surgery of the right meniscectomy in 05/2013, 5 Synvisc injections to the right knee, 24 physical therapy sessions and a knee brace. Diagnostic studies included an x-ray of the right knee, which revealed the right knee is significantly filled with osteoarthritis and is bone on bone. bone on bone. On 01/15/2015, it was noted the injured worker complained of pain to his right knee and the right anterior thigh and could no longer bear full weight. He described his pain level at 4-6/10 despite his use of ibuprofen and Lyrica. He complained of increased pain in the right knee whenever he shifts his weight and stated the orthopedic surgeon had recommended a total knee replacement. Objective physical examination findings revealed range of motion to the right knee with flexion to 125 degrees, extension -10 degrees with positive patellar compression test and positive patellar grind test. The injured worker has had a total of 5 Synvisc injections to the right knee over the last 2 to 5 years, which gave him only temporary relief, relief from the last injection lasting 2 months. He has completed over 24 physical therapy sessions with no improvement to the right knee. His current medications include ibuprofen, tramadol and Lyrica. The treatment plan was for right knee replacement followed by physical rehabilitation. Tramadol was added to the medication regimen. The request was for: (1) Total knee replacement of the right knee; (2) a hospital stay of 2 days; (3) physical therapy 2 to 3 times a week for 4 weeks; (4) postop cold therapy unit rental for 4 weeks; (5) and MRI Zimmer of the right knee and the rationale was because the injured worker had failed all conservative measures of treatment and his activities of daily living are at a minimum. The Request for Authorization form dated 01/12/2015 was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery total replacement for the right knee QTY: 1.00: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Knee joint replacement.

Decision rationale: The request for surgery for total knee replacement for the right knee is medically necessary. The injured worker presented is a 55 year old male with complaints of increasing right knee and right anterior thigh pain and could not bear full weight. According to the Official Disability Guidelines for knee replacement, the patient has completed conservative care including physical therapy and medications plus subjective clinical findings of limited range of motion less than 90% for total knee replacement and nighttime joint pain and no relief from the conservative care; and documentation of current functional limitations demonstrating necessity of intervention plus objective clinical findings of the patient being over 50 years of age and body mass index of less than 40; plus imaging clinical findings of osteoarthritis on x-ray documenting significant loss of chondral clear space in at least 1 of 3 compartments or previous arthroscopy documenting advanced chondral erosion or exposed bone. The injured worker has reported pain that effects his ADLs and his sleep. The injured worker has failed conservative care including physical therapy, injections and a brace. His range of motion flexion is at 125 degrees; however, extension is at negative 10 degrees, which creates functional deficits. The x-rays indicated bone on bone. As such, the request for surgery total knee replacement of the right knee is medically necessary.

In patient hospital stay for 2 days: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Hospital length of stay (LOS).

Decision rationale: The inpatient hospital stay for 2 days is medically necessary. The injured worker presented with complaints of increasing right knee and right anterior thigh pain. According to the Official Disability Guidelines, the hospital length of stay recommendation for a total knee replacement is a median of 3 days with no complications. The request for total knee replacement has been approved. Therefore, the request for inpatient hospital stay of 2 days is medically necessary.

Post op physical therapy 2-3 times a week for four 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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Physical medicine treatment.

Decision rationale: The request for postop physical therapy 2 to 3 times a week for 4 weeks is not medically necessary. The injured worker presented with increasing right knee and right anterior thigh pain. According to the guidelines for physical therapy, there should be an evaluation to formally assess after a 6 visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction prior to continuing with physical therapy. As such, the request for physical therapy 2 to 3 times a week for 4 weeks is not medically necessary.

Post op cold therapy unit rental for 4 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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Continuous-flow cryotherapy.

Decision rationale: The request for postop cold therapy unit rental for 4 weeks is not medically necessary. The injured worker presented with complaints of increasing right knee and right anterior thigh pain. According to the Official Disability Guidelines continuous flow cryotherapy is recommended as an option after surgery and may be up to 7 days including home use. The request for unit rental for 4 weeks exceeds the guidelines without indicating any exceptional factors. As such, the request for postop cold therapy unit rental for 4 weeks is not medically necessary.

MRI zimmer of the right knee: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, MRI's (magnetic resonance imaging).

Decision rationale: The request for MRI Zimmer of the right knee is not medically necessary. The injured worker presented with increasing right knee and right anterior thigh pain. According to the Official Disability Guidelines, routine use of an MRI for follow-up of asymptomatic

patients following knee arthroplasty is not recommended, but may be appropriate for pain after total knee replacements with a negative x-ray for loosening or low probability of infection. As such, the MRI is not recommended after knee surgery without having a prior x-ray. Therefore, the request for MRI Zimmer of the right knee is not medically necessary.