

Case Number:	CM14-0201691		
Date Assigned:	12/12/2014	Date of Injury:	08/28/2000
Decision Date:	01/30/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/02/2014

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 Occupational 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:

The applicant is a represented [REDACTED] employee who has filed a claim for chronic knee pain reportedly associated with an industrial injury of August 28, 2000. In a Utilization Review Report dated November 25, 2014, the claims administrator failed to approve a request for laboratory testing to include an ESR, CRP, knee aspiration, and associated labs. Non-MTUS guidelines were invoked. A progress note of November 18, 2014 was also cited. The applicant had apparently undergone a revision total knee arthroplasty, it was stated but had apparently sustained a recent fall. The claims administrator's rationale was very difficult to follow. In one section of the note, the claims administrator stated that it was citing ACOEM, while other sections of the note comprised almost entirely of non-MTUS guidelines of various sources. The claims administrator contended that there was no evidence or suspicion of infection for which the laboratory testing at issue would have been indicated. The applicant's attorney subsequently appealed. In an office visit dated November 18, 2014, the applicant reported persistent complaints of knee pain status post revision total knee arthroplasty in March 2012 to rectify a loose prosthesis. The applicant had undergone ankle surgery in January 2013. The applicant had developed a postoperative ankle infection which had been treated. The applicant now reported some heightened knee complaints reportedly associated with a fall. The applicant stated that her knee pain was worsened with weightbearing. The applicant drank rarely, it was stated. -5 to 150 degrees of knee of range of motion were appreciated with some tenderness appreciated about the medial tibial plateau. X-rays of the knee demonstrated an indwelling revision total knee prosthesis with a "cloud" around the tibial sleeve. The attending provider stated that he interpreted these studies to represent radiographic evidence of tibial loosening. An ESR, CRP, and aspiration of the left knee were endorsed. The attending provider stated that he might possibly need to revise the prosthesis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Labs: ESR and CRP: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): Table 13-1, page 331. Decision based on Non-MTUS Citation American College of Radiology (ACR), Appropriateness Criteria of Imaging after Total Knee Arthroplasty

Decision rationale: As noted in the MTUS Guideline in ACOEM Chapter 13, Table 13-1, page 331, an abnormal CBC, abnormal ESR, and, by implication, an abnormal CRP are red flags for potentially serious knee conditions such as inflammation and/or septic arthritis, both of which are apparently suspected here. The attending provider did state that he suspects a periprosthetic infection status post total knee arthroplasty. Both the American College of Radiology (ACR) and American Academy of Orthopedic Surgery (AAOS) recommend usage of ESR and CRP testing in applicants being assessed for periprosthetic joint infection. Here, the attending provider, an orthopedic knee surgeon, seemingly contended that the applicant either had issues with joint loosening and/or superimposed issues with a periprosthetic infection. Performing ESR and CRP laboratory testing to determine the likelihood of infection is indicated, appropriate, and supported by ACOEM, ACR, and AAOS. Therefore, the request is medically necessary.

Knee aspiration and labs: cultures, gram stain, cell count: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339, 346. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339. Decision based on Non-MTUS Citation American College of Radiology (ACR), Appropriateness Criteria of Imaging after Total Knee Arthroplasty.

Decision rationale: While the MTUS does not specifically address the topic of aspiration and culture in applicants with an infected total knee prosthesis, the MTUS Guideline in ACOEM Chapter 13, page 339 does support an aspiration, Gram stain, culture, sensitivity, and possible lavage in applicants with severe knee pain with motion with suspected septic effusion of the knee joint. The American College of Radiology (ACR) and American Academy of Orthopedic Surgery (AAOS), however, takes the position that the combination of ESR and CRP represents good screening tools for infection with only one infected knee having negative results on both sides having been discovered in one study. ACR and AAOS recommend joint aspiration in applicants being assessed for periprosthetic knee infections who have abnormal ESR and/or CRP results. Here, however, the attending provider has stated that the most likely operating diagnosis is that of periprosthetic loosening as opposed to a periprosthetic infection. X-rays taken on

November 18, 2014 demonstrated periprosthetic loosening/tibial loosening. The applicant also exhibited near-normal range of motion from -5 to 115 degrees on this date. There were no overt signs or symptoms of infection evident. Using the ESR and CRP as screening tools, thus, is likely the most appropriate option here, as suggested by ACOEM, ACR, and AAOS as negative ESR and CRP test results would likely obviate the need for the proposed knee aspiration and culture. Therefore, the request is not medically necessary.