MAXIMUS Federal Services

Case Number:	CM14-0204661		
Date Assigned:	12/16/2014	Date of Injury:	11/26/1997
Decision Date:	02/25/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/08/2014

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:

39 year old female claimant with an industrial injury dated 11/28/97. Exam note 11/06/14 states the patient returns with left knee pain. The patient explains the pain as an aching, stabbing, burning, throbbing, catching pain in which is almost constant. The patient rates the pain an 8/10 at its worst and 1/10 at its least. The patient explains that the pain increases with repetitive movements including flexing, extension, squatting, twisting and turning. The pain is noted to radiate to the medial distal on the thigh. Current medications include Motrin, Norco, Xanax, and Wellbutrin for pain relief. Upon physical exam the patient demonstrated a normal gait with a heel to toe progression with a slight guard on the left. Range of motion was noted as 5'-110' of flexion. There was evidence of moderate tenderness surrounding the mid medial joint line with no lateral joint line tenderness. The patient had slight atrophy on the left thigh when compared to the right. When the patient demonstrated an active flexion and extension there was moderate retropatellar crepitation and popping. MRI left knee on 8/20/14 demonstrates intact medial and lateral collateral ligaments with Grade 2 to Grade 3 chondral inhomogeneity in the lateral aspect of the medial femoral condyle. Treatment includes a left patellofemoral resurfacing, and a continuation with medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery Left Patellofemoral Resurface Procedure, Left 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 (ODG); Treatment Workers' Compensation (TWC); Integrated Treatment / Disability Duration 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 and Leg, 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 11/6/14 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 request is not medically necessary.

Associated Surgical Services: Durable Medical Equipment (DME) Vascutherm Intermittent PCD or DVT, 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.

Associated Surgical Services: In-Patient Hospital Two to Three Day Stay, 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.