

Case Number:	CM14-0207082		
Date Assigned:	01/30/2015	Date of Injury:	08/22/2002
Decision Date:	03/12/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/10/2014

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:

The injured worker is a 67 year old female who sustained a work related injury August 22, 2002. Past medical history includes diagnoses of hypertension, kidney disease stage III, thyroid disease, anxiety and s/p cervical fusion in 1991. According to initial workers compensation orthopedic evaluation performed November 6, 2014, the physician documented the original injury as falling from a ladder backwards onto a rolling rack and the left knee was caught between the ladder rungs, during the fall. Treatment to date in regard to her knees includes medications, physical therapy, TENS unit, multiple cortisone and Synvisc injections, pain management, left knee arthroscopy 2002 and left total knee May 14, 2014. At presentation the injured worker complains of bilateral knee pain, right worse, 6-7/10 and occasionally sharp and burning with occasional pins and needles. The pain is aggravated with prolonged walking, standing and stairs and alleviated with sitting and elevation of legs. She stated her left knee is improved since surgery but she is limited in activity. AP/Lat/Sunrise views of the left knee (undated) demonstrate well-fixed total knee components. There is no evidence of migration or loosening; the patella appears to be well tracking. The joint space is symmetrical with no evidence of polyethylene wear (report not present in medical record). Physical examination of the right knee reveals a significant limp, trace swelling with obvious varus deformity, moderate tenderness along the medial joint line with palpable osteophytes present. Range of motion was noted as; extension 10 degrees, and flexion 120 degrees. McMurray's and Apley's are negative, Valgus (MCL) 1 + laxity correcting to neutral or 0 degrees alignment. Left knee gait is normal, range of motion; extension 0 degrees, flexion 120 degrees and stable. Diagnoses are documented

as left total knee arthroplasty and right knee medial degenerative arthritis. Treatment includes discussion and requests for a scanogram hip to ankle and a stress valgus alignment view and possible uni-versus total knee arthroplasty. A primary physician's progress report dated November 13, 2014, finds the injured worker presenting with complaints of muscle spasms and cramps in the bilateral anterior thigh regions, cervical pain which radiates to the top of the head and into bilateral shoulder regions. She has been receiving physical therapy for her neck and reports it has helped. Current medications include Cytomel, Synthroid, Baclofen, Nucynta, Voltaren, and Lisinopril. On examination there is a positive McMurray's test to medial right knee pain and positive ballottement test on the left side. Treatment recommendations included authorization requests for mediations, 30 day trial of a TENS unit, discussed possible surgery of the right knee, and signed a new narcotic contract. Work status temporarily totally disabled. A request for authorization was made November 13, 2014, for right total knee arthroplasty and associated pre-operative testing, length of stay and post-operative equipment and treatment. Regarding pre-operative chest x-ray are not addressed by MTUS ACOEM and cite ACC/AHA 2007 guidelines on per-operative cardiovascular evaluation and care for non-cardiac surgery, American College of Cardiology Foundation- Medical Specialty Society American Heart Association- Professional Association 1996 March 15(revised 2007 Oct). The injured worker had a history of hypertension, however, the requested surgery was not recommended and therefore, the request is non-certified. Regarding pre-operative lab tests are not addressed by MTUS ACOEM and cited Danielson D Bjork, Carl R Foreman J, Harper C , Roemer, R Stultz J, Sypura W. Thompson S, Webb B. Preoperative evaluation, Bloomington (MN): Institute for Clinical Systems Improvements (ICSI); 2012 Jul. 61 p.[36 references]. The surgery was not recommended and therefore the chest-xray is non-certified. Regarding 3 day length of stay and citing Official Disability Guidelines (ODG) which recommend a length of stay up to 3/1 days. However, the surgery was non-certified and therefore the 3 day length of stay is non-certified. Regarding the request for in-home and post-operative physical therapy and citing MTUS ACOEM Guidelines, physical therapy is recommended post-operatively up to 24 sessions with a post surgical period lasting up to 4 months. However, as the surgery was non-certified, the in-home and post-operative physical therapy is non-certified as well. Regarding the rental of a cold compression unit, the Official Disability Guidelines (ODG) recommends up to 7 days use as an option after surgery. However, as the surgery was non-certified, the cold compression unit is non-certified. Regarding the use of a walker MTUS ACOEM Guidelines do not make recommendations regarding their use. Disability, pain, and age related impairment determine the need for a walking aid. The requested surgery was non-certified, as such the walker is non-certified. Regarding the post-operative use of a commode, the Official Disability Guidelines(ODG) state this is used as a convenience in the home and necessary if the patient is bed or room confined. As the surgery is not recommended the commode is non-certified. Regarding the request for continuous passive motion(CPM) unit, the Official Disability Guidelines(ODG) state it is recommended for in-hospital use or for home patients at risk. The surgery was not recommended and therefore the CPM unit is non-certified. Regarding the request for the scanogram, Official Disability Guidelines, Knee & Leg (Acute & Chronic) recommend a computed tomography (CT) study as an option for knee pain conditions with negative radiograph. The requested surgery was not certified, therefore the scanogram is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

right total knee arthroplasty between 11/6/14 and 1/12/15: 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 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 11/13/14 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. Therefore the guideline criteria have not been met and the determination is for non-certification.

chest x-ray between 11/6/14 and 1/12/15: 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.

EKG between 11/6/14 and 1/12/15: 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.

set of lab tests: CBC, CMP, PT, PTT, and UA between 11/6/14 and 1/12/15: 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.

3-day hospitalization between 11/6/14 and 1/12/15: 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 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.

physical therapy at home - 6 sessions between 11/6/14 and 1/12/15: 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 - 12 sessions between 11/6/14 and 1/12/15: 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 between 11/6/14 and 1/12/15: 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 Knee and Leg, Continuous flow cryotherapy

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

walker between 11/6/14 and 1/12/15: 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 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.

3-in-1 commode between 11/6/14 and 1/12/15: 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 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 between 11/6/14 and 1/12/15: 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 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.

scanogram - right lower extremity between 11/6/14 and 1/12/15: 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 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.