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| Case Number: | CM15-0003889 | | |
| Date Assigned: | 02/13/2015 | Date of Injury: | 10/30/2013 |
| Decision Date: | 04/09/2015 | UR Denial Date: | 12/29/2014 |
| Priority: | Standard | Application Received: | 01/08/2015 |

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: Illinois, California, Texas
 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 57-year-old male who sustained an industrial injury on 10/30/13. Past surgical history was positive right knee arthroscopy with partial meniscectomy and chondroplasty of the medial femoral condyle, trochlear groove, and patella on 3/5/14. The operative report documented grade 2-3 changes on the medial femoral condyle. Records documented that the patient completed a series of Supartz injections and was using an unloader brace in the post-operative period, with residual significant medial compartment tenderness. The 11/4/14 treating physician report cited worsening right knee pain with limping. Right knee exam documented full extension with 110 degrees flexion, trace effusion, and mild joint line tenderness to palpation. The knee was stable to varus, valgus, and anterior/posterior stresses. X-rays showed bilateral medial joint line narrowing and moderate tricompartmental arthritis disease. The diagnosis was right knee sprain/strain with underlying osteoarthritis. The injured worker desired to move forward with total knee replacement as he had failed all conservative treatment including medication, activity modification, physical therapy, and injections. The treating physician requested right total knee arthroplasty, physical therapy x 22 sessions, and CPM and cold therapy unit, which is now under review. On 12/29/14, utilization review non-certified a request for right total knee arthroplasty, physical therapy x 22 sessions, and CPM and cold therapy unit. The rationale for non-certification cited the absence of a formal imaging report documenting degenerative arthritis in the right knee, and lack of a documented body mass index. The California MTUS ACOEM and Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right 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- Knee and Leg.

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: Knee Joint Replacement.

Decision rationale: The California MTUS does not provide recommendations for total knee arthroplasty. The Official Disability Guidelines recommend total knee replacement when surgical indications are met. Specific criteria for knee joint replacement include exercise and medications or injections, limited range of motion (< 90 degrees), nighttime joint pain, no pain relief with conservative care, documentation of functional limitations, age greater than 50 years, and a body mass index (BMI) less than 40. Guidelines require imaging clinical findings of osteoarthritis on standing x-ray (documenting significant loss of chondral clear space in at least one of the three compartments, with varus or valgus deformity an indication with additional strength), or on previous arthroscopy (documenting advanced chondral erosion or exposed bone, especially if bipolar chondral defects are noted). Guideline criteria have not been fully met. The treating physician has documented x-ray evidence of moderate tricompartmental osteoarthritis with medial joint line narrowing bilaterally. There was no varus or valgus deformity noted. There is no documentation of night-time joint pain, range of motion less than 90 degrees, or body mass index less than 40. Therefore, this request is not medically necessary at this time.

(Associated services) Physical therapy x 22 sessions: 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 services) CPM and cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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: Continuous passive motion (CPM); Continuous flow cryotherapy.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.