

Case Number:	CM15-0105265		
Date Assigned:	06/12/2015	Date of Injury:	02/28/2003
Decision Date:	09/02/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	06/01/2015

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: 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 53 year old female, who sustained an industrial injury on February 28, 2003. The injured worker has been treated for bilateral knee complaints. The diagnoses have included right knee osteoarthritis, left knee arthrosis, bilateral knee meniscal tearing, bilateral knee chondromalacia and bilateral carpal tunnel syndrome. Treatment to date has included medications, radiological studies, physical therapy, and bilateral knee surgery. Current documentation dated April 7, 2015 notes that the injured worker reported bilateral knee pain, greater on the right. The pain was characterized as aching, burning, and stabbing. The injured worker also noted pain in the left ankle and foot. Examination of the right knee revealed tenderness to palpation over the medial joint line with crepitus and a loss of body marks. Range of motion was noted to be decreased. A grind maneuver was positive. BMI is noted to be 32. The treating physician's plan of care included a request for a right total knee arthroplasty, ice unit, continuous passive motion machine (duration unspecified), front wheel walker, pre-operative clearance, home help (duration and frequency unspecified), two day inpatient stay, psychological clearance, post-operative evaluation by a registered nurse, Lovenox 30 mg injections, Ultracin cream 120 ml, orthopedic re-evaluation within 6 weeks, post-operative Zofran 8 mg #10, Duracef 500 mg (quantity unspecified), Norco 10/325 mg #60 and post-operative physical therapy #8.

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 Page(s): s 343- 344. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee.

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of total knee replacement. According to the Official Disability Guidelines regarding Knee arthroplasty the criteria for knee joint replacement 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 4/7/15 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 request is not medically necessary.

Ice 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 flow cryotherapy.

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

Continuous Passive Motion (CPM) (duration unspecified): 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 section, CPM.

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

Front Wheel Walker: 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 chapter, Walking aids.

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

Pre-operative Clearance: 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) Low Back, Preoperative testing.

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

Home Help (duration & frequency unspecified): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

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

2 Day Inpatient Stay: 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), Hospital Length of Stay (LOS), Knee Replacement.

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, Hospital length of stay.

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

Psychological Clearance: 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) Low back, Preoperative testing.

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

Post-operative Evaluation by RN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

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

Lovenox 30mg injection 1 x q12 hrs x 10 days: 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, Venous thrombosis.

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

Ultracin Cream 120ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): s 111-112.

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

Orthopedic re-evaluation within 6 weeks: 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) Pain, Office visits.

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

Post-op Zofran 8mg #10: 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) Pain Chapter, Ondansetron (Zofran).

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

Duracef 500mg (quantity unspecified): 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) Infectious Disease Chapter, Cefadroxil (Duracef).

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

Norco 10/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

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