

<b>Case Number:</b>	CM15-0013569		
<b>Date Assigned:</b>	02/02/2015	<b>Date of Injury:</b>	02/16/2010
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	01/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/23/2015

### 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 52-year-old male with a reported injury on 03/29/2011. The mechanism of injury was not clearly provided. His diagnoses include the injured worker is status post a left knee arthroscopy with osteochondral allograft transplantation to the medial femoral condyle on 02/20/2013. His diagnoses included knee sprain and left knee osteoarthritis. The injured worker's past treatments included cortisone injections and medications. The injured worker's diagnostic testing included an MRI of the left knee performed on 08/22/2013, which demonstrated 2 osteochondral allografts within the weight-bearing region of the medial femoral condyle. They appeared to be well placed with the adjacent chondral surfaces, and allograft marrow demonstrates low T1 signal and hyperintense T2 signal which was normal at 3 months postop, but could represent rejection if it persists beyond 6 to 12 months. On 01/09/2015, the injured worker reported short term improvement following his most recent cortisone injection. Otherwise, there have been no significant changes with the exception of some increased discomfort secondary to recent cold weather. Upon physical examination of the left knee, there was no evidence of effusion. Range of motion was demonstrated from 0 to 135 degrees. Severe quadriceps weakness was demonstrated with markedly decreased tone. The knee demonstrated no evidence of erythema, ecchymosis, or warmth; and all incisions were well healed. There was no tenderness to palpation demonstrated along the medial/lateral joint line. The patellofemoral articulation demonstrated minimal crepitus without compression pain, soft tissue pain, or swelling; and patellar mobility was normal. Ligament examination of the knee was stable. The injured worker's medication included amoxicillin 500 mg, Feldene 10 mg, and ibuprofen 600

mg. The request was for decision for surgery musculoskeletal system, femur thigh region, knee joint repair revision reconstruction, arthroplasty knee condyle and plateau medial and lateral compartments with or without patella resurfacing; physical medicine, physical therapy and rehabilitation 2 times a week for 4 weeks; decision for durable medical equipment, heat cold application water circulation cold pad with pump for 7 days; and Lovenox. The rationale for the request was not clearly provided. The Request for Authorization form was not submitted for review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Surgery musculoskeletal system, femur thigh region, knee joint repair revision reconstruction, arthroplasty knee condyle and plateau medial and lateral compartments with or without patella resurfacing:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345.

**Decision rationale:** The request for surgery musculoskeletal system, femur thigh region, knee joint repair revision reconstruction, arthroplasty knee condyle and plateau medial and lateral compartments with or without patella resurfacing is not medically necessary. According to the California MTUS/ACOEM Guidelines, surgical considerations may be indicated for patients who have activity limitation and failure of exercise programs to increase range of motion and strength of the musculature around the knee. The injured worker reported short term improvement following his most recent cortisone injection. Upon physical examination, the patient was noted with quadriceps weakness and minimal crepitus. The knee was stable with range of motion demonstrated from 0 to 135 degrees. The documentation did not provide sufficient evidence of tried and failed conservative care (to include physical therapy, home exercise program, and medications). The documentation did not indicate significant functional limitations. Additionally, the documentation did not provide recent imaging clinical findings to warrant a surgical procedure at this time. Given the above, the request is not supported. As such, the request is not medically necessary.

**Lovenox:** 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 [www.drugs.com/lovenox.html](http://www.drugs.com/lovenox.html).

**Decision rationale:** The request for Lovenox is not medically necessary. The documentation did not provide a clear rationale for the medical necessity of the anticoagulant at this time. The

documentation did not indicate a history of DVT or risk factors for blood clots. Given the above, the request is not supported. As such, the request is not medically necessary.

**Physical medicine, physical therapy and rehabilitation 2 times a week for 4 weeks:** 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 Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg, Physical medicine treatment.

**Decision rationale:** The decision for physical medicine, physical therapy and rehabilitation 2 times a week for 4 weeks is not medically necessary. According to the California MTUS Guidelines, active therapy may be recommended based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Patients are instructed and expected to continue active therapy at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance, and functional activities with assistive devices. The documentation did not specify the number of completed physical therapy sessions to the right knee to date. The documentation did not provide sufficient evidence of significant objective functional improvement or a significant objective decrease in pain as a result of the completed physical therapy. Given the above, the request is not supported. As such, the request is not medically necessary.

**Durable medical equipment, heat cold application water circulation cold pad with pump for 7 days:** 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 Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg, Physical medicine treatment.

**Decision rationale:** The decision for physical medicine, physical therapy and rehabilitation 2 times a week for 4 weeks is not medically necessary. According to the California MTUS Guidelines, active therapy may be recommended based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Patients are instructed and expected to continue active therapy at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance, and functional activities with assistive devices. The documentation did not specify the number of completed physical therapy sessions to the right knee to date. The documentation

did not provide sufficient evidence of significant objective functional improvement or a significant objective decrease in pain as a result of the completed physical therapy. Given the above, the request is not supported. As such, the request is not medically necessary.