MAXIMUS Federal Services

Case Number:	CM15-0013622		
Date Assigned:	02/02/2015	Date of Injury:	02/15/2006
Decision Date:	04/09/2015	UR Denial Date:	01/08/2015
Priority:	Standard	Application Received:	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 49-year-old female, who sustained an industrial injury on 2/15/06. She has reported back and lower extremity injuries after falling off a ladder. The diagnoses have included reflex sympathetic dystrophy osteoarthritis of the lower leg, generalized osteoarthritis and lumbago. Treatment to date has included medications, diagnostics, bracing, lumbar blocks, spinal cord stimulator, physical therapy, mental health evaluations, injections and functional restoration program. Surgery included right and left knee arthroscopy currently, per recent physician progress note dated 12/15/14, the injured worker complains of left knee pain and wears a hinged left knee brace status post fall injury at summit pain management. She continues with functional restoration program and noticed improvement in symptoms. She notes improvement with biofeedback. She has seen orthopedics who recommend diagnostic arthroplasty since she cannot have a Magnetic Resonance Imaging (MRI) due to the dorsal column stimulator. The pain with medication was rated 7-8/10 and without medications was a 10/10 on pain scale. Physical exam revealed she ambulated using bilateral Canadian crutches and hinged knee brace on the left leg is in poor condition. There was 1+ effusion on the right knee, anterior tenderness, left foot with hyperesthesia and allodynia. There was moderate swelling and erythema in the dorsal foot but not the toes and moderate right lower extremity allodynia, distal edema. There was physical therapy sessions noted. On 1/8/15, Utilization Review non-certified a request for Left knee patellofemoral vs. bicompartmental arthroplasty with MAKO system and Associated surgical service: Inpatient hospital stay x 1 day, noting as per the American Journal of Orthopedics (Belle Mead New Jersey) 2009 February; 38 16-9 perioperative management of unicompartmental knee

arthroplasty using the MAKO robotic arm system (MAKOplasty), Official Disability Guidelines (ODG), Hospital length of stay were cited. On 1/8/15, Utilization Review modified a request for Post-op physical therapy evaluation and 12 sessions modified to Post-op physical therapy evaluation and 6 sessions, noting (MTUS) Medical Treatment Utilization Schedule post surgical treatment guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left knee patellofemoral vs bicompartmental arthroplasty with MAKO system: 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, 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 12/15/14 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.

Associated surgical service: Inpatient hospital stay x 1 day: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Hospital length of stay.

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 evaluation and 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 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.