

<b>Case Number:</b>	CM15-0184555		
<b>Date Assigned:</b>	10/01/2015	<b>Date of Injury:</b>	06/04/2004
<b>Decision Date:</b>	12/11/2015	<b>UR Denial Date:</b>	09/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/19/2015

### 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, Indiana, Oregon  
 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 68-year-old female, with a reported date of injury of 06-04-2004. The diagnoses include left knee osteoarthritis. Treatments and evaluation to date have included cortisone injections, Voltaren gel, Naprosyn, Orthovisc injection series, and Kohana cream. The diagnostic studies to date have included an MRI of the left knee on 10-14-2013, which showed very early osteoarthritic changes on the medial aspect of the tibiofemoral joint, a small horizontal tear at the junction of anterior horn and mid-segment of the lateral meniscus, and joint effusion. The medical report dated 08-10-2015 indicates that the injured worker had a history of long- standing knee pain, which had worsened over time. It was noted that the cortisone injections had not resolved her pain. Her symptoms were "now affecting her everyday life and activity" according to the treating physician. The physical examination showed carpus throughout range of motion; extension at -4 degrees; flexion at 110 degrees; mild effusion; no ligamentous laxity; crepitus throughout range of motion; and negative straight leg raise. An x-ray of the left knee on the day of the visit showed complete joint space collapse of the medial compartment with levels of degenerative joint disease in both lateral and patellofemoral joint. The treatment plan included a total knee arthroplasty as a definitive treatment. The treating physician indicated that the injured worker developed post-traumatic arthritis, have had meniscal tears, and arthroscopic debridement in the past. The injured worker's work status was not indicated. The request for authorization was dated 08-19-2015. The treating physician requested a left total knee arthroplasty, two to three day inpatient stay, assistant physician's assistant, pre-operative EKG, pre-operative labs, and medical clearance. On 09-11-2015, Utilization Review

(UR) non-certified the request for a left total knee arthroplasty, two to three day inpatient stay, assistant physician's assistant, pre-operative EKG, pre-operative labs, and medical clearance.

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

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

#### **Left total knee arthroplasty: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation, Knee and Leg (Acute and Chronic) (updated 07/10/15) ODG Indications for Surgery- Knee arthroscopy.

**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.

**Decision rationale:** The 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 that 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. In this case, there is no clear radiographic evidence of significant chondral clear space loss in 2 of 3 compartments on standing radiographs. The request is not medically necessary.

#### **Assistant PA: 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.

#### **Pre-operative EKG: 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.

**Pre-operative labs:** 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 surgical service: Medical clearance:** 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 surgical service: 2-3 days inpatient stay:** 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.