

<b>Case Number:</b>	CM15-0188953		
<b>Date Assigned:</b>	10/01/2015	<b>Date of Injury:</b>	05/01/2002
<b>Decision Date:</b>	12/11/2015	<b>UR Denial Date:</b>	08/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2015

### 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 66 year old female who sustained an industrial injury on 05-01-2002. A review of the medical records indicated that the injured worker is undergoing treatment for left knee medial compartment joint space narrowing, bone-on-bone with tricompartmental degenerative changes. The injured worker is status post left knee surgery in 2002 and 2006 (no procedures documented). According to the treating physician's progress report on 08-11-2015, the injured worker continues to experience left knee pain rated at 5-7 out of 10 on the pain scale associated with popping, clicking, giving way and weakness. Evaluation noted a slow gait favoring the left lower extremity range of motion limited at flexion 90 degrees and extension at 0 degrees. There was mild edema and medial and lateral joint tenderness. Motor strength in the left quadriceps muscles was 4 out of 5. McMurray's and Steinman's tests were positive. Recent left knee magnetic resonance imaging (MRI) dated 07-09-2015 was reported by the treating physician in the review on 08-11-2015. The injured worker has requested a second surgical opinion prior to consenting for the left total knee arthroplasty. Current medication was listed as Ibuprofen. Treatment plan consists of continuing home exercise program, continuing with Ibuprofen, second surgical opinion and the current request for left total knee arthroplasty, post op physical therapy (24 sessions) for the left knee, preoperative evaluation, three day hospital stay, walker, continuous passive range of motion machine, cold therapy unit, home health post-operative physical therapy 3 times a week for 2 weeks (6 sessions), home healthcare five hours a day for seven days a week for 2 weeks post-operatively, Aspirin 325mg, narcotic pain medication (unspecified). On 08-31-2015 the Utilization Review determined the request for left

total knee arthroplasty, post op physical therapy (24 sessions) for the left knee, preoperative evaluation, three day hospital stay, walker, continuous passive range of motion machine, cold therapy unit, home health post-operative physical therapy 3 times a week for 2 weeks (6 sessions), home healthcare five hours a day for seven days a week for 2 weeks post-operatively, Aspirin 325mg, narcotic pain medication (unspecified) was not medically necessary at this time until injured worker has her second opinion.

### **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 (ODG).

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

**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. In this case the August 11 BMI is calculated at 41.9. The request is not medically necessary.

#### **Post op physical therapy (24 sessions) for the left knee: 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.

#### **Preoperative evaluation: 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.

**Three day hospital 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.

**Walker:** 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.

**Continuous passive range of motion machine:** 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.

**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 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.

**Home health post op physical therapy (6) sessions 3x2:** 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.

**Home healthcare five hours a day for seven days a week for two weeks post operatively:**  
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.

**Aspirin 325mg:** 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.

**Narcotic pain medication 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 Medical Treatment 2009, Section(s): Opioids, dosing.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. In this case, the dosage and medication are not specified. Medical necessity cannot be established.