MAXIMUS Federal Services

Case Number:	CM15-0202249		
Date Assigned:	10/19/2015	Date of Injury:	02/07/2005
Decision Date:	11/30/2015	UR Denial Date:	09/25/2015
Priority:	Standard	Application Received:	10/14/2015

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, Oregon, Washington
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 72 year old female who sustained an industrial injury on 2-7-05. A review of the medical records indicates she is undergoing treatment for cervical and lumbar strain, chronic stenosis of the lumbar spine, lumbar disc disease with disk herniation, right shoulder impingement syndrome, status post left total knee replacement, compensatory right knee, worsening pain from favoring the left, status post carpal tunnel release, shoulder tendonitis, and right knee medial meniscus tear. Medical records (7-30-15) indicate complaints of "increasing right knee pain". She rates the pain "6-8 out of 10" and reports that her activities of daily living are affected due to right knee pain, limiting her ability to walk. She also complains of bilateral wrist pain. The physical exam (7-30-15) reveals medial joint line tenderness of the right knee with positive compression test. The treating provider states that the injured worker "presents with right knee effusion with notable clicking and crepitus on both active and passive range of motion". "Notable locking within the right knee" is also noted. Diagnostic studies have included an MRI of the right knee showing tears of medical meniscus with interval progression, advanced chondromalacia of the medial knee compartment and patella, multioculated cysts within the posteriomedial knee, degenerative osteophytes - mostly in the medial knee compartment, and joint effusion. Treatment recommendations include platelet-rich plasma injection to the left knee and right knee arthroscopic surgery with meniscectomy. The utilization review (9-25-15) includes requests for authorization of platelet-rich plasma injection to the left knee, physical therapy of the left knee three times weekly for six weeks, and

pre-op clearance. Physical therapy was modified to two sessions. The platelet-rich plasma injection to the left knee and pre-op clearance were denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

Platelet rich plasma injection to the left knee: 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-TWC) - Criteria for Platelet-rich plasma (PRP), intra-articular injection.

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, PRP.

Decision rationale: CA MTUS/ACOEM is silent on the issue of platelet-rich plasma (PRP) for the knee. According to the ODG, Knee and Leg, PRP, "Under study. PRP looks promising, but it is not yet ready for prime time. PRP has become popular among professional athletes because it promises to enhance performance, but there is no science behind it yet. A study of PRP injections in patients with early arthritis compared the effectiveness of PRP with that of low-molecular-weight hyaluronic acid and high-molecular-weight hyaluronic acid injections, and concluded that PRP is promising for less severe, very early arthritis, in younger people under 50 years of age, but it is not promising for very severe osteoarthritis in older patients." As the guidelines do not support PRP for the knee, the determination is for non-certification. The request is not medically necessary.

Physical therapy to the left knee, 2 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Knee.

Decision rationale: Per the CA MTUS/Post Surgical Treatment Guidelines, page 24, Knee, arthroplasty of the knee recommends 24 visits over 10 weeks with a post surgical treatment period of 4 months. The guidelines recommend of the authorized visit initially therefore 12 visits are medically necessary. As the current request is beyond the 4 month period after surgery (left TKA was 5/11/12), the determination is for non-certification. The request is not medically necessary.

Pre-operative clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7: Independent Medical Examinations and Consultations.

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 general.

Decision rationale: CA MTUS/ACOEM is silent on the issue of preoperative clearance and testing. ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. ODG states, These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high risk surgery and those undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is a 72 year old without comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed surgical procedure. Therefore the determination is for non-certification. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.