

Case Number:	CM15-0027301		
Date Assigned:	03/02/2015	Date of Injury:	03/22/2012
Decision Date:	04/10/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	02/12/2015

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: Illinois, California, Texas
 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 45-year-old female who sustained an industrial injury on 3/22/12. Past surgical history was positive for left unicompartmental arthroplasty on 2/5/14. The 2/5/14 operative report documented findings of global degenerative joint disease, including the lateral and patellofemoral joints. The 9/3/14 left knee MRI revealed displacement of the femoral component into varus. The 10/23/14 treating physician report indicated the patient had increased left knee pain and discomfort with giving way. X-rays showed the medial compartment femoral component had moved and was in a varus position. A revision and replacement with total knee rather than a unicompartmental knee was recommended. The 1/8/15 treating physician report indicated the patient had failed unicompartmental knee arthroplasty. She had an antalgic gait and walked with a cane, with an obvious displaced prosthesis. Physical exam documented abnormal heel to toe gait with reciprocation for imbalance, unequal stride lengths and stance time, and abnormal velocity. Left total knee arthroplasty was requested. On 1/15/15, utilization review modified the request for left knee arthroplasty to revision left total knee arthroplasty. The request for a cold therapy unit was modified to 7 days rental and the request for continuous passive motion unit was modified to 21 days rental. The request for post-operative pain pump was non-certified. The Official Disability Guidelines were cited.

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) Knee Chapter-Knee Arthroplasty.

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: Knee joint replacement; Revision total knee arthroplasty.

Decision rationale: The California MTUS does not provide recommendations for primary or revision total knee arthroplasty. The Official Disability Guidelines recommend total knee replacement when surgical indications are met. Specific criteria for knee joint replacement include exercise and medications or injections, limited range of motion (< 90 degrees), night-time joint pain, no pain relief with conservative care, documentation of functional limitations, age greater than 50 years, a body mass index (BMI) less than 40, and imaging findings of osteoarthritis. Revision total knee arthroplasty is recommended for failed knee replacement when surgical indications are met. Criteria include recurrent disabling pain, stiffness and functional limitation that have not responded to appropriate conservative nonsurgical management (exercise and physical therapy), fracture or dislocation of the patella, component instability or aseptic loosening, infection, or periprosthetic fractures. The 1/15/15 utilization review modified the request for left total knee arthroplasty to a revision total knee arthroplasty. The request is consistent with a revision arthroplasty and meets guideline criteria relative to pain, functional limitation, failure of conservative treatment, and component displacement. There is no compelling reason provided to support authorization beyond the modified certification. Therefore, this request is not medically necessary.

Associated Surgical Services-Cold Therapy Unit: 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) Knee Chapter- Continuous-Flow Cryotherapy.

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: Continuous flow cryotherapy.

Decision rationale: The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous-flow cryotherapy is an option for up to 7 days in the post-operative setting following knee surgery. The 1/15/15 utilization review decision recommended partial certification of a cold therapy unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.

Associated Surgical Services-CPM Unit: 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) Knee Chapter-CPM.

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: Continuous passive motion (CPM).

Decision rationale: The California MTUS does not provide recommendations for this device following total knee replacement. The Official Disability Guidelines state that the use of a continuous passive motion device may be considered medically necessary in the acute hospital setting for 4 to 10 days (no more than 21 days) following total knee replacement and for home use up to 17 days while the patient at risk of a stiff knee is immobile or unable to bear weight following a primary or revision total knee arthroplasty. The 1/15/15 utilization review modified the non-specific request for a continuous passive motion unit to a 21-day rental. There is no compelling reason in the medical records to support the medical necessity of a continuous passive motion unit beyond the 21-day rental already certified. Therefore, this request is not medically necessary.

Post op Pain pump: 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) Knee Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Post-op ambulatory infusion pumps (local anesthetic) Shoulder, Postoperative pain pump.

Decision rationale: The California MTUS guidelines are silent regarding this device. The Official Disability Guidelines indicate that post-op ambulatory infusion pumps for local anesthetic are under study. Guidelines do not recommend post-operative pain pumps and state there is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures. Given the absence of guideline support for the use of post-operative pain pumps, this request is not medically necessary.