MAXIMUS Federal Services

Case Number:	CM15-0030062		
Date Assigned:	02/23/2015	Date of Injury:	03/09/2013
Decision Date:	05/01/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	02/18/2015

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, Sports Medicine

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 46-year-old male who reported injury on 03/09/2013. The injured worker underwent physical therapy. The injured worker underwent a left knee CT scan. The documentation indicated the injured worker had a prior meniscus surgery with medial knee pain and a twisting injury. The findings revealed mild to moderate diffuse tricompartmental degenerative fossa arthritis, greater in the medial compartment where moderate joint space was narrowing and subchondral bone changes were present. The findings were similar to the prior MRI. There were medial tibial surgical changes with screw sites, 1 of which extended through the posterior weight bearing surface of the medial tibial plateau that was unchanged. There was marked osteoporosis. There was attenuated medial meniscus midbody and postoperative scarring in the medial infrapatellar fat pad. The documentation of 12/04/2014 revealed the injured worker had pain in the anteromedial aspect of the left knee. The diagnoses included left knee medial meniscus posterior horn root avulsion with moderate to severe medial compartment DJD with grade IV chondromalacia medial patella status post left knee arthroscopic surgery with meniscal repair, synovectomy, and chondroplasty. The treatment plan included a CT scan of the left knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Makoplasty, Unicompartmental Knee Replacement for 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) Knee Chapter, Indications for Surgery - 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 & Leg Chapter, Arthroplasty.

Decision rationale: The Official Disability Guidelines indicate a unicompartmental replacement may be considered if only 1 compartment is affected. There should be documentation of exercise therapy and medications, plus limited range of motion and nighttime joint pain and no pain relief with conservative care, and there should be documentation of current functional limitation demonstrating necessity for intervention. There should be documentation the injured worker is over 50 years of age and has a body mass index of less than 40. There should be documentation of osteoarthritis on standing x-rays. The clinical documentation submitted for review failed to provide documentation of standing x-rays. However, the injured worker had significant findings on MRI which would not support the necessity for a unicompartmental replacement. The injured worker had findings upon MRI that would support a total knee joint replacement. There was a lack of documentation indicating the injured worker had limited range of motion and nighttime joint pain and no pain relief with conservative care. There was a lack of documentation of current functional limitations. The injured worker's body mass index was not provided. There was no physician rationale submitted or documentation requesting the surgical intervention. Given the above, the request for Makoplasty, Unicompartmental Knee Replacement for the Left Knee is not medically necessary.

Pre-Operative 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.

Pre-Operative Chest X-Ray: 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.

Post-Operative Physical Therapy 2 x week x 4 weeks 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.

Associated Surgical Service: In-patient hospital stay x 2 days: 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.

Post-Operative Cold Therapy Unit, 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.