MAXIMUS Federal Services

| Case Number: | CM15-0032950 | | |
|---|---|---|---|
| Date Assigned: | 02/26/2015 | Date of Injury: | 03/19/2008 |
| Decision Date: | 04/17/2015 | UR Denial Date: | 01/30/2015 |
| Priority: | Standard | Application Received: | 02/23/2015 |

## 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

## 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 42-year-old female who reported an injury on 03/19/2008. The injured worker was reportedly riding a Segway up an emergency ramp when she hit a bump causing her to fall and land on her left side. The current diagnosis is left knee monoarthritis. The injured worker presented on 12/30/2014 for an orthopedic consultation. The injured worker has been previously treated with medications, several injections, and physical therapy. The injured worker also underwent a previous surgery in 2012, which provided mild relief of symptoms. The injured worker presented with complaints of pain, stiffness, and instability of the left knee. The current medication regimen includes tramadol, hydrocodone, Ambien, and ibuprofen. Upon examination of the left knee, there was mild swelling noted. Flexion was noted at 95 degrees with a contracture at 7 degrees. There was mild crepitus noted with range of motion testing and 4+/5 motor weakness. There was mild tenderness to palpation noted over the medial joint line. X-rays obtained in the office revealed advanced degenerative changes with complete loss of the medial compartment space. Recommendations included a total knee arthroplasty. A Request for Authorization form was then submitted on 01/14/2015.

## 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 & Leg Chapter, Knee joint replacement.

**Decision rationale:** The Official Disability Guidelines recommend a knee arthroplasty when 2 out of 3 compartments are affected. Conservative treatments should include exercise therapy and medications or injections. Patients should be over 50 years of age with a body mass index of less than 40. There should be documentation of osteoarthritis upon standing x-ray or upon a previous arthroscopy report. In this case, it is noted that the injured worker has complaints of chronic left knee pain. However, there is limited documentation of objective deficits. There were no official imaging studies provided for review. There is also limited documentation of a recent attempt at conservative measures to include active rehabilitation. The injured worker is less than 50 years of age. The body mass index was not provided. Given the above, the request is not medically appropriate at this time.

**3 day inpatient 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.

**Assistant surgeon:** 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.

**Medical clearance to include PFT and Echo if indicated:** 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.

**DME: walker, cryotherapy machine, 3 in 1 commode, kneehab/TENS unit with conductive garment/supplies - 4 months:** 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.