

Case Number:	CM15-0042696		
Date Assigned:	03/12/2015	Date of Injury:	12/01/2011
Decision Date:	04/16/2015	UR Denial Date:	03/05/2015
Priority:	Standard	Application Received:	03/06/2015

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 a 50-year-old male who sustained an industrial injury on 12/1/11. The mechanism of injury was not documented. Past surgical history included left knee surgery on 7/2/13, and a left unicondylar replacement and lateral release on 5/14/14. The 12/16/14 left knee MRI impression documented a medial femorotibial unicompartmental arthroplasty, and low articular cartilage within the patellofemoral and lateral femorotibial compartments, most pronounced in the patellofemoral compartment, and a small popliteal cyst. The 1/19/15 orthopedic report cited giving way and weakness with left leg and foot numbness and tingling. Physical exam documented atrophy, 4/5 quadriceps and gastroc strength, paresthesias, and positive patellar compression test. There was a 20 degrees flexion deficit secondary to pain. The diagnosis was patellar malalignment chondromalacia, radial tear medial meniscus, grade IV chondromalacia medial femoral condyle, and severe degenerative joint disease medial femoral condyle. Authorization was requested for left knee patellofemoral arthroplasty. The 1/29/15 treating physician report cited worsening post-op knee replacement pain with pain radiating down posteriorly from this knee. Left knee pain was 7/10 without medications, and 5-6/10 with medications. Physical exam documented medial joint line and superior patellar tenderness, painful motion of the patella, and discomfort with patellar compression test. Left knee range of motion was -3 to 150 degrees. The diagnosis was left knee internal derangement, chondromalacia patella, and radial tear of the medial meniscus. Additional surgical treatment was discussed. The 2/5/15 EMG/NCV report impression documented electrical evidence of left peroneal neuropathy, left knee, and no left lower extremity radiculopathy. The 3/4/15 utilization

review non-certified the request for left patellofemoral arthroplasty and post-op physical therapy as there was a lack of clinical information to approve the surgery and no documentation as to why only a patellofemoral arthroplasty was being requested versus a conversion to a total knee arthroplasty.

IMR ISSUES, DECISIONS AND RATIONALES

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

Patellofemoral Arthroplasty, Left Knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 18th Edition, 2013, Knee & Leg Chapter, Risk Versus Benefit.

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.

Decision rationale: The California MTUS does not provide recommendations for knee arthroplasty. The Official Disability Guidelines recommend knee joint replacement when surgical indications are met. If only one compartment is affected, a unicompartmental or partial replacement may be considered. If 2 of the 3 compartments are affected, a total joint replacement is indicated. Specific criteria for knee joint replacement include exercise and medications or injections, limited range of motion (< 90 degrees), nighttime 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. Guideline criteria have not been met. The patient presents status post medial femorotibial unicompartmental arthroplasty with electrodiagnostic evidence of left peroneal neuropathy. There is no current imaging evidence of osteoarthritis limited to the patellofemoral compartment, with low cartilage reported in both the patellofemoral and lateral compartments. Current clinical exam does not suggest range of motion less than 90 degrees, nighttime joint pain, or specific functional limitations. There is no documentation of the patient's height, weight, or body mass index. There is no discussion regarding the medical necessity of partial arthroplasty over conversion to a total knee arthroplasty. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

Post Operative Physical Therapy for the Left Knee QTY: 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

