

Case Number:	CM15-0060997		
Date Assigned:	04/08/2015	Date of Injury:	07/15/2009
Decision Date:	07/03/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	03/31/2015

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:

This injured worker is a 64-year-old male who sustained an industrial injury on 7/15/09. Injury occurred when he was climbing into his truck and felt a pop in his right knee. Past medical history was positive for Type 2 diabetes, heart disease (stent in 2005), asthma, Past surgical history was positive for right knee surgery in 2010 and left knee surgery in 2011. Conservative treatment had included medications, physical therapy, Orthovisc injection, activity modification, and hinged knee braces. The 2/12/15 treating physician report cited grade 7/10 bilateral knee pain with weakness, swelling, stiffness, numbness and tingling. He had night time pain and pain with every step. He reported associated weakness, swelling, stiffness, numbness and tingling in both knees. He reported radiating pain up and down both legs from the knee pain. He was not currently working. Body mass index was 37.38. Knee exam documented range of motion 5 to 120 degrees bilaterally. He had a varus deformity that was not passively correctable, but minimally deformed. Radiographs were taken of the knees and showed tricompartmental severe disease. The diagnosis was bilateral knee osteoarthritis. The treatment plan recommended bilateral total knee replacement, right before the left. Authorization was requested for right total knee replacement, post-operative physical therapy 3x4, front wheeled walker, and pre-operative clearance (EKG/Labs-CBC, CMP, PTT, PT, INR, HgA1c, MRSA swab). The 3/12/15 utilization review non-certified the right total knee replacement and associated surgical requests as there was no specific interpretation of x-ray findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Total Knee Replacement: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery - Knee arthroplasty, Criteria for knee joint replacement.

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 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. Guideline criteria have been met. This injured worker presents with bilateral knee pain with swelling and weakness. Night-time pain was documented. Functional difficulty was noted in ambulation. There was limited range of motion with varus deformity. X-rays showed severe tricompartmental osteoarthritis. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Associated surgical service: Physical therapy 3x4 weeks to start 3-5 days after surgery:
Overturned

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

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

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for knee arthroplasty suggest a general course of 24 post-operative visits over 10 weeks during the 4-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. This request for physical therapy is consistent with guidelines for initial post-operative treatment. Therefore, this request is medically necessary.

Associated surgical service: DME - Front Wheeled Walker: Overturned

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 & Leg (Acute & Chronic) Walking aids (canes, crutches, braces, orthoses & walkers).

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, Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: The California MTUS guidelines do not provide specific guidelines for post-op ambulatory assistant devices. The Official Disability Guidelines state that disability, pain, and age-related impairments determine the need for a walking aid. Assistive devices can reduce pain and allow for functional mobility. The use of a front wheel walker seems reasonable to allow for early post-op functional mobility and in light of bilateral knee osteoarthritis. Therefore, this request is medically necessary.

Pre-operative clearance (EKG/Labs-CBC, CMP, PTT, PT, INR, HGA1c, MRSA swab):
Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116 (3): 522-38.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. Guideline criteria have been met based on patient's age, significant co-morbidities, the magnitude of surgical procedure, recumbent position, fluid exchange and the risks of undergoing anesthesia. Therefore, this request is medically necessary.