

Case Number:	CM14-0126860		
Date Assigned:	08/13/2014	Date of Injury:	01/30/2012
Decision Date:	09/30/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/11/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Sports Medicine and is licensed to practice in Maryland. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 59 year old female who sustained an injury on 01/30/12 when she was knocked down suffering transverse fracture of the tibia with development of traumatic arthritis in the bilateral knees. The injured worker was found to have severe osteoporosis due to a prior gastric bypass and subsequent extensive weight loss at almost 200 pounds. The injured worker underwent recent left total knee arthroplasty on 05/13/14. Post-operatively the injured worker continued with complaints of right knee pain. Radiographs from 12/13 showed marked valgus deformity bilaterally. There were no independent radiographic records available for review. As of 06/11/14 the injured worker continued to report complaints of left and right knee pain. The injured worker requested new brace for the right knee. On physical examination range of motion was limited in the left knee at 110 degrees. No specific findings at the right knee were reported. The injured worker was recommended for right total knee arthroplasty. Follow up on 07/30/14 noted the injured worker had no improvement in right knee following Synvisc injections or physical therapy. The injured worker was utilizing a brace to correct the valgus deformity in the right knee however the injured worker continued to however the injured worker was reported to have tricompartmental disease with biconcave deformities in the medial femoral condyle. On physical examination range of motion of the right knee was restricted to 95 degrees flexion and 10 degree extension lag. There was notable crepitus on range of motion. Palpable osteophytes were present and there was a positive compression sign bilaterally. No instability was identified and there was no weakness present. Radiographs in office noted advanced osteoarthritis of the right knee involving the lateral joint compartment with external rotational deformity and valgus alignment. The requested right total knee arthroplasty with post-operative purchase of DME physical therapy Norco and Aspirin were denied by utilization review on 07/25/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Total Knee Arthroplasty: 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 Official Disability Guidelines (ODG) Knee & Leg Chapter, Knee Joint Replacement.

Decision rationale: In regards to the total knee arthroplasty this reviewer would have recommended this request as medically necessary based on clinical documentation submitted for review and current evidence based guidelines. The injured worker presents with severe osteoarthritis in the right knee with valgus deformity. There is notable loss of range of motion crepitus and palpitation of osteophytes on physical examination. Symptoms have no improved with prior physical therapy or viscosupplementation injections. Given the severity of the osteoarthritic findings in the right knee it is highly unlikely that this injured worker would improve with further non-operative treatment. Given the objective findings consistent with right knee osteoarthritis that has failed conservative treatment this reviewer would have recommended this request as medically necessary.

Purchase of Front Wheel Walker: 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 Official Disability Guidelines (ODG) Knee and Leg Chapter, Walking Aides.

Decision rationale: In regards to the front wheeled walker this reviewer would have recommended this request as medically appropriate. The injured worker would reasonably require stabilization during ambulation following the right knee osteoarthritis right knee arthroplasty procedure. The injured worker recently had a left knee arthroplasty and due to the considerable post-operative pain the injured worker will experience, a front wheeled walker would be reasonable to prevent further falls from occurring. Therefore this reviewer would have recommended this request as medically necessary.

Purchase of Don Joy Phoenix Brace: Upheld

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 Official Disability Guidelines (ODG) Knee & Leg Chapter, Knee Brace.

Decision rationale: In regards to Don Joy Phoenix brace this reviewer would not have recommended this request as medically necessary. There is no indication from the clinical records that a customized brace would be required over a standard post-operative brace for the right knee. Therefore this request was not medically necessary.

Post Operative Physical Therapy three times a week for four weeks to the Right Knee:
Overturned

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

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

Decision rationale: In regards to post-operative physical therapy for 12 sessions, three times a week for four weeks, this reviewer would have recommended this request as medically appropriate. The injured worker would reasonably require post-operative rehabilitation following surgery to improve strength and range of motion in the right knee. The amount of physical therapy requested would be consistent with guideline recommendations. Therefore this reviewer would have recommended this request as medically necessary.

Norco #80 unknown quantity: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 88-89.

Decision rationale: In regards to Norco #80 this reviewer would not have recommended this request as medically necessary. Although the injured worker would have reasonably required post-operative analgesics for pain control the request is not specific in terms of dose frequency or duration. Therefore this reviewer would not have recommended this request as medically necessary.

Aspirin 325mg unknown quantity: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

Decision rationale: In regards to Aspirin 325mg this reviewer would not have recommended this request as medically necessary. Although the injured worker recently required post-operative medications for inflammation and swelling and pain the request is not specific in regards to quantity frequency or duration. Therefore this reviewer would not have recommended this request as submitted as medically necessary.