

Case Number:	CM14-0147064		
Date Assigned:	09/15/2014	Date of Injury:	04/24/1995
Decision Date:	10/15/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/10/2014

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 Occupational Medicine and is licensed to practice in California. 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:

This is a 76 year old male with a 4/24/95 injury date. He stepped forward off the curb at the back of the office while going to the company car, and came down on his left knee. In a follow-up on 3/19/14, subjective findings included left knee soreness that is controlled with Celebrex, medial sided knee pain with activity, and no recent deterioration in function. Overall, he is happy with the knee. Objective findings included normal gait, left knee range of motion from 0 to 110 degrees, trace effusion, and grade 2 laxity on varus/valgus stress. Left knee x-rays on 3/19/14 showed loose bodies and good component positioning. A left knee CT on 5/7/14 showed subchondral cysts below the metallic prosthesis in the medial tibial plateau and subchondral cysts in the patellar face. In particular, there were two prominent cysts below the tibial implant, one measuring 2.7X1.6X1.7 cm and one measuring 2.5X1.1X2 cm. The provider indicates that surgery to prevent failure should be done within one year. Diagnostic impression: left knee s/p total knee arthroplasty (TKA), possible osteolysis. Treatment to date: left TKA (2006), physical therapy, walker, and home care. A UR decision on 8/28/14 denied the request for revision left TKA on the basis that there has not been an office visit since May 2014. In addition, the patient notes mild discomfort and exam findings are minimal, whereas guidelines state that revision TKA should be considered when there is recurrent disabling pain, functional limitation, fracture or dislocation of the patella, instability of the components, infection, or periprosthetic fracture. The requests for assistant surgeon and 3-day hospital stay were denied because the surgical procedure was not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Revision Left TKA with Poly Exchange & Possible Allograft Bone Grafting: 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 Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Knee Chapter.

Decision rationale: CA MTUS does not address this issue. ODG indicates that revision TKA is recommended for failed knee replacement or internal fixation, as indicated below. Prostheses are generally very durable; however, in some cases failure does occur, requiring a revision of the TKR. When assessing the need for revision TKR, conditions such as disabling pain, stiffness, and functional limitation which are unrelieved by appropriate nonsurgical management and lifestyle changes should all be considered. Evidence of progressive and substantial bone loss alone is considered sufficient reason to consider revision in advance of catastrophic prosthesis failure; furthermore, fracture or dislocation of the patella, instability of the components or aseptic loosening, infection, and periprosthetic fractures are also common reasons for total knee revision. In the present case, the patient has minor knee pain and exam findings are not really impressive, although there is some varus/valgus laxity, which can be seen in cases of prosthetic loosening. However, the subchondral cysts below the tibial implant are quite large, presenting significant risk or loosening (if not already loose) or catastrophic failure. In addition, the guidelines do support revision surgery on the basis of substantial bone loss alone. A poly exchange and allograft bone grafting would be routine and necessary components of the revision surgery in this case. Therefore, the request for Revision Left TKA with Poly Exchange & Possible Allograft Bone Grafting is medically necessary.

Assistant Surgeon: 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 Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Orthopedic Surgeons (AAOS).

Decision rationale: CA MTUS and ODG do not address this issue. American Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics states on the role of the First Assistant: According to the American College of Surgeons: "The first assistant to the surgeon during a surgical operation should be a trained individual capable of participating and actively assisting the surgeon to establish a good working team. The first assistant provides aid in exposure, hemostasis, and other technical functions, which will help the surgeon carry out a safe operation and optimal results for the patient. The role will vary considerably with the surgical operation, specialty area, and type of hospital. "The first assistant's role has traditionally been filled by a variety of individuals from diverse

backgrounds. Practice privileges of those acting as first assistant should be based upon verified credentials reviewed and approved by the hospital credentialing committee (consistent with state laws)." In general, the more complex or risky the operation, the more highly trained the first assistant should be. Criteria for evaluating the procedure include:-anticipated blood loss - anticipated anesthesia time -anticipated incidence of intraoperative complications -procedures requiring considerable judgmental or technical skills -anticipated fatigue factors affecting the surgeon and other members of the operating team -procedures requiring more than one operating team. In limb reattachment procedures, the time saved by the use of two operating teams is frequently critical to limb salvage. It should be noted that reduction in costly operating room time by the simultaneous work of two surgical teams could be cost effective. In the present case, the complexity of the proposed surgery merits the use of an assistant surgeon. Therefore, the request for an assistant surgeon is medically necessary.

3 day inpatient stay: 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 Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Knee Chapter

Decision rationale: CA MTUS does not address this issue. ODG recommends a 4-day length of stay after revision TKA, which is within the limits of the requested 3-day inpatient stay. Therefore, the request for 3-day inpatient stay is medically necessary.