

Case Number:	CM14-0162160		
Date Assigned:	10/07/2014	Date of Injury:	02/25/2009
Decision Date:	11/04/2014	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	10/02/2014

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 Physical Medicine & Rehabilitation, 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 60 year-old male laborer sustained an injury on 2/25/09 when he fell while descending a step ladder during employment with [REDACTED]. There are other reports identifying injury when he fell while lifting a box. Request(s) under consideration include CT both knees. There is comobidites with past medical history of hypertension, diabetes, and gastritis. The patient underwent Right total knee arthroplasty (TKA) on 5/13/11 and gradually developed reported compensatory left knee pain attributed to altered gait with subsequent Left TKA on 9/11/12. AME evaluation of 3/26/14 noted patient with ongoing chronic bilateral knee symptoms with limitations on exam in range, tenderness, no atrophy, 5/5 motor strength, ambulating with a cane. The patient has not returned to any modified work since injury date. Bilateral knee x-rays were done with right knee showing 1/2 centimeter gap between cement and medial bone consistent with prosthesis loosening with loose body of medial patella impacting medial femoral condyle. The left x-rays showed well-placed cemented total knee replacement without significant loosening and only slight lucency between tibial tray and medial tibial plateau. It was opined the patient may require right knee surgery revision with recommendation for prior aspiration and bone scan to rule out infection. Conservative care has included medications, therapy, and modified activities/rest. Report of 8/26/14 from the provider noted the patient with ongoing right knee pain rated at 7/10. Exam showed tenderness at left lateral knee, right patella and right medial knee; range of 0-120 degrees with 4/5 motor strength. No diagnoses were documented. Treatment plan included X-rays and MRI of lumbar spine, UDS, medication refills, Chiropractic/ PT 3x4, CT scan of left knee, Interferential unit and motorized cold therapy unit with patient remaining TTD status. The request(s) for CT both knees were non-certified on 9/5/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT both knees: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee chapter, Computed tomography (CT)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints
Page(s): 341-342.

Decision rationale: This 60 year-old male laborer sustained an injury on 2/25/09 when he fell while descending a step ladder during employment with [REDACTED]. There are other reports identifying injury when he fell while lifting a box. Request(s) under consideration include CT both knees. There is comorbidities with past medical history of hypertension, diabetes, and gastritis. The patient underwent Right total knee arthroplasty (TKA) on 5/13/11 and gradually developed reported compensatory left knee pain attributed to altered gait with subsequent Left TKA on 9/11/12. AME evaluation of 3/26/14 noted patient with ongoing chronic bilateral knee symptoms with limitations on exam in range, tenderness, no atrophy, 5/5 motor strength, ambulating with a cane. The patient has not returned to any modified work since injury date. Bilateral knee x-rays were done with right knee showing 1/2 centimeter gap between cement and medial bone consistent with prosthesis loosening with loose body of medial patella impacting medial femoral condyle. The left x-rays showed well-placed cemented total knee replacement without significant loosening and only slight lucency between tibial tray and medial tibial plateau. It was opined the patient may require right knee surgery revision with recommendation for prior aspiration and bone scan to rule out infection. Conservative care has included medications, therapy, and modified activities/rest. Report of 8/26/14 from the provider noted the patient with ongoing right knee pain rated at 7/10. Exam showed tenderness at left lateral knee, right patella and right medial knee; range of 0-120 degrees with 4/5 motor strength. No diagnoses were documented. Treatment plan included X-rays and MRI of lumbar spine, UDS, medication refills, Chiropractic/ PT 3x4, CT scan of left knee, Interferential unit and motorized cold therapy unit with patient remaining TTD status. The request(s) for CT both knees was non-certified on 9/5/14. It is unclear if the patient has undergone knee aspiration or bone scan as recommended by the AME for the right knee. There appears to be no indication for bilateral knee CT scan at this time when the previous left knee x-rays showed well-placed cemented TKR without loosening. There has been no updated X-rays or progression in symptom complaints or clinical findings with acute red-flag conditions to support for bilateral CT knee scan. The patient remains ambulatory with adequate range of 0-120 degrees. Guidelines criteria for imaging study include joint effusion within 24 hours of direct blow or fall/trauma, inability to walk or bear weight immediately or within a week of the trauma, inability to flex the knee to 90 degrees, significant hemarthrosis or red-flag issues, not demonstrated here. The CT both knees is not medically necessary and appropriate.