

<b>Case Number:</b>	CM14-0096683		
<b>Date Assigned:</b>	07/28/2014	<b>Date of Injury:</b>	09/26/2001
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	05/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/25/2014

### 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, 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:

The claimant is a 64-year-old gentleman who injured his left knee in work-related accident September 26 2001. The clinical records provided for review included the May 14, 2014, office note documenting continued left knee complaints for the diagnosis of advanced degenerative arthritis. Plain film radiographs on that date revealed severe left knee degenerative joint disease. Subjectively, the claimant complained of joint instability, locking and popping. Physical examination showed moderate swelling, decreased left knee range of motion, a 5 degree extensor lag, lateral joint line tenderness and positive crepitation. The office note documented specifically the treatment to date had included medications. There was a request for a left total knee arthroplasty due to the claimant's failed conservative care, continued symptoms and advanced degenerative arthritis. The medical records did not contain any other imaging reports or documentation of other forms of conservative treatment. The claimant's body mass index was not noted. In addition, the physician recommended postoperative use of a CPM machine, home healthcare, physical therapy and a pre-operative MRI for planning purposes.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LEFT TOTAL KNEE REPLACEMENT:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, INDICATIONS FOR SURGERY

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Comp, 18th Edition, 2013 Updates: knee procedure

**Decision rationale:** California MTUS and ACOEM Guidelines do not provide criteria relevant to this request. Based on the Official Disability Guidelines, the request for left total knee arthroplasty is not recommended as medically necessary. The medical records document that advanced degenerative arthritis, there is no documentation to confirm that the claimant has exhausted all benefit of conservative treatment including injection therapy of corticosteroid or viscosupplementation. There is also no documentation of the claimant's height, weight, or body mass index. The Official Disability Guidelines support failure of conservative measures and objective findings demonstrating a body mass index of less than 35. Therefore, the medical records do not meet the guideline criteria for total knee arthroplasty.

**LEFT KNEE MRI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341, 343.

**Decision rationale:** Based on California ACOEM Guidelines, an MRI scan of the claimant's left knee also would not be indicated. This request is made in reference to planning purposes for the custom implant for the joint replacement surgery. The proposed left total knee replacement is not recommended as medically necessary and therefore, the request for an MRI scan for preoperative planning purposes would not be medically necessary.

**CONTINUOUS PASSIVE MOTION X21 DAYS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, CONTINUOUS PASSIVE MOTION

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp; 18th Edition; 2013 Updates; Chapter Knee; CPM

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**HOME HEALTH CARE/NURSING X 7 DAYS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines HOME HEALTH CARE.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**HOME PHYSICAL THERAPY X 6:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services, Page(s): 51, Postsurgical Treatment Guidelines.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**OUTPATIENT PT 3X4 = 12:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.