

Case Number:	CM14-0214102		
Date Assigned:	12/31/2014	Date of Injury:	01/14/2013
Decision Date:	02/25/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/22/2014

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. 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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 57-year-old male who reported injury on 01/14/2013. Mechanism of injury was not submitted for review. The injured worker has a diagnosis of status post mechanical fall twice on 01/14/2013; left wrist strain; left wrist scaphocapitate arthritis; right wrist scapholunate disassociation; left shoulder pain; cervical strain; spondylolisthesis at C4-5; history of right knee ACL reconstruction; right knee osteoarthritis with severe medial joint pain; and anterior horn medial meniscal tear left knee, status post partial medial meniscectomy, anterior and posterior horn small lateral meniscal tear status post partial medial and lateral meniscectomy. Past medical treatments consist of surgery, physical therapy and medication therapy. Medications include Norco and Motrin. Diagnostics include MRIs of the left wrist, MRI of the right wrist, x-rays and MRIs of the cervical spine, and MRI of the lumbar spine. 11/17/2014: The injured worker complained of severe pain. He said the right knee pain did not radiate. Symptoms include clicking, locking, swelling, burning pain, grinding, popping, stabbing, stiffness, weakness, warmth, catching and tenderness. The injured worker rated the pain at a 9/10. Physical examination revealed both knees were tender. There was no evidence of range of motion, sensory deficits, muscle strengths or special testing. Treatment plan is for the injured worker to continue with medication therapy and undergo a right knee total replacement. There was no rationale or Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right total knee replacement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- knee joint replacement, indications for surgery- knee arthroplasty

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345.

Decision rationale: The request for right total knee replacement is not medically necessary. According to the California MTUS/ACOEM Guidelines, criteria for surgical considerations are: activity limitations for more than 1 month and/or failure in exercise program to increase range of motion and strength of the musculature around the knee. It was indicated in the submitted report that the injured worker was postop anterior horn medial meniscal tear of the left knee with partial medial meniscectomy, anterior and posterior horn small lateral meniscal tear. There was no indication of the injured worker having trialed and failed conservative treatment, nor was there any indication of the injured worker having decreased in range of motion or strength. Physical examination simply stated that both knees were tender. Furthermore, there was no indication of activity limitations. Given the above, medical necessity cannot be established. As such, the request is not medically necessary.

2-3 days inpatient hospital stay: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- hospital length of stay.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Assistant surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American college of surgeons et al. Physicians as assistants at surgery 2002 study. www.facs.org

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Medical clearance with internal medicine: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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