

<b>Case Number:</b>	CM15-0129465		
<b>Date Assigned:</b>	07/21/2015	<b>Date of Injury:</b>	09/04/2002
<b>Decision Date:</b>	08/17/2015	<b>UR Denial Date:</b>	06/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/06/2015

### 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, Indiana, Oregon  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 66 year old female patient who sustained an industrial injury on 09/04/2002. A radiographic study done on 03/27/2009 showed a magnetic resonance imaging scan of the left knee with a grade III internal signal degeneration in the posterior horn of the medial meniscus with abnormal signal extending up but not clearly through the articular surface. Again, on 08/04/2011 a MRI showed the left knee with stable severe thinning of the medial patellar facet articular cartilage, and focal subchondral marrow edema at the lateral patellar facet has decreased in size since prior study. Lastly, again on 07/22/2014, a MRI of the left knee showed tricompartmental osteoarthritis particularly affecting the patellofemoral and medial compartments including advanced median patellar ridge/medial patellar facet chondral loss. There is joint effusion synovitis as well as loculation of cystic fluid along the posterior border of the knee. There is note of inner free edge tear of the mid-zone of the lateral meniscus as well as fraying and subtle tear of the inner free edge of the posterior horn of the medial meniscus. A secondary treating visit dated 12/11/2014 reported the patient receiving an injection on 09/29/2014 with some temporary benefit to left knee pain. She has also been attending physical therapy and noted improvement in symptoms. The assessment found the patient with left knee medial and patellofemoral compartment osteoarthritis. She is to continue with therapy course and contemplate a follow up injection. A primary treating follow up dated 04/29/2015 reported the patient with subjective complaint of with severe left knee pain and difficulty ambulating with a walker. The following diagnoses were applied: left knee degenerative arthritis

with degenerative meniscal tears; chronic low back pain; right shoulder pain, and right ankle pain. There is continued recommendation for the patient to undergo a left knee replacement.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Left Knee Replacement Arthroplasty: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Knee Chapter (online version), Knee joint replacement.

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of total knee replacement. According to the Official Disability Guidelines regarding Knee arthroplasty: Criteria for knee joint replacement which includes conservative care with subjective findings including limited range of motion less than 90 degrees. In addition the patient should have a BMI of less than 35 and be older than 50 years of age. There must also be findings on standing radiographs of significant loss of chondral clear space. In this case BMI is not documented and official interpretation of standing radiographs is not presented to evaluate chondral clear space loss. Based on this the request is not medically necessary.

#### **Pre-op EKG: 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.

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

#### **Labs: CMP/ eGFR, PT, UA/ RflCul, CBC/ Diff, APTT, ABO/ Rh: 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.

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

### **Post-op Home Physical Therapy 3 x 2: 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.

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

### **Outpatient Physical Therapy 3 x 6: 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.

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

### **Norco 10-325mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47 and 48, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 80.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. There is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity from the exam note of 4/29/15. Therefore the request is not medically necessary.

### **Celebrex 200mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Chapter (online version).

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

**Decision rationale:** CA MTUS/Chronic Pain Medical Treatment Guidelines, page 70 states that Celecoxib (Celebrex) is for use with patients with signs and symptoms of osteoarthritis, rheumatoid arthritis and ankylosing spondylitis. ODG pain is referenced. Celebrex has not been shown to be more effective than other NSAIDs, but has a significant increased cost. Based on this the request for this brand name drug is not medically necessary.

**Tramadol 50mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines tramadol Page(s): 93-94.

**Decision rationale:** Per the CA MTUS Chronic Pain Medical Treatment Guidelines pages 93-94, Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is indicated for moderate to severe pain. Tramadol is considered a second line agent when first line agents such as NSAIDs fail. There is insufficient evidence in the records of 4/29/15 of failure of primary over the counter non-steroids or moderate to severe pain to warrant Tramadol. Therefore use of Tramadol is not medically necessary.

**Keflex 500mg #28:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Working Group of the Clinical Practice Guidelines for the patient safety at surgery settings; Agency for information, Evaluation and Quality in Health of Catalonia, 2010, page 191.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Stulberg DL, Penrod MA, Blatny RA. Common bacterial skin infections. Am FamPhysician. 2002 Jul 1;66(1):119-24.

**Decision rationale:** CA MTUS/ACOEM and ODG are silent on the issue of Keflex. And alternative guideline was utilized. According to the American Family Physician Journal, 2002 July 1; 66 (1): 119, 125, titled "Common Bacterial Skin Infections", Keflex is often the drug of choice for skin wounds and skin infections. It was found from a review of the medical record submitted of no evidence of a wound infection to warrant antibiotic prophylaxis. The request for Keflex is therefore not medically necessary and appropriate.

**3 Day Inpatient Stay:** 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.

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