

<b>Case Number:</b>	CM15-0176818		
<b>Date Assigned:</b>	09/28/2015	<b>Date of Injury:</b>	01/24/2003
<b>Decision Date:</b>	11/02/2015	<b>UR Denial Date:</b>	08/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2015

### 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, Oregon, Washington  
 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, who sustained an industrial injury on January 24, 2003. The initial symptoms reported by the injured worker are unknown. The injured worker was diagnosed as status post left knee total arthroscopy, May 4, 2005, with revision times two, lumbar spine sprain and bilateral sciatica, cervical spine sprain with left upper extremity radiculopathy, mixed anxiety-depressive disorder and gastroesophageal reflux disease secondary to NSAIDs use. Treatment to date included diagnostic studies, medications, surgery, braces, injections and physical therapy. On March 21, 2014, x-ray of the left knee showed degenerative marginal osteophytes of the medial femoral condyle articular surface and medial tibial plateau articular surface, degenerative marginal osteophytes of the lateral femoral condyle articular surface and lateral tibial plateau articular surface, degenerative marginal osteophytes of the posterior aspect of the patellar upper pole and patellar lower pole, degenerative traction patellar osteophytes off the upper pole anteriorly and metallic femoral and tibial components of the total knee replacement with no specific radiographic signs of loosening. On July 24, 2015, the injured worker complained of recurrent right shoulder pain radiating to the right thumb from using her cane at home. Notes stated that most of the pain her pain interferes with her ability to travel, engage in social activities and with concentration and thinking clearly. Her pain level was rated as a 9 on a 1-10 pain scale on average. Medications and a follow-up visit were recommended. On August 3, 2015, utilization review denied a request for left knee total arthroplasty, post-operative physical therapy of the left knee three times a week for four weeks with therapeutic exercises and cold therapy with non-sterile cold pad and wrap seven-day rental.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Left total knee arthroplasty:** 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 and leg chapter.

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

**Decision rationale:** Per ODG, the Criteria for Revision total knee arthroplasty include the following: Recurrent disabling pain, stiffness and functional limitation that has not responded to appropriate conservative nonsurgical management (exercise and PT); Fracture or dislocation of the patella; Instability of the components or aseptic loosening; Infection; Periprosthetic fractures. In this case none of the above conditions apply and thus the request is not medically necessary.

**Post-operative physical therapy of the left knee, 3 times a week for 4 weeks, with therapeutic exercises:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated surgical service: Cold therapy with non-sterile cold pad and wrap x 7 day rental:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.