

<b>Case Number:</b>	CM15-0178638		
<b>Date Assigned:</b>	09/23/2015	<b>Date of Injury:</b>	09/30/2011
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	08/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2015

### 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 52 year old male, who sustained an industrial-work injury on 9-30-11. A review of the medical records indicates that the injured worker is undergoing treatment for end stage left knee post traumatic degenerative joint disease (DJD) status post tibial hardware removal. Medical records dated 7-10-15 indicate that the injured worker is for follow up regarding the left knee status post tibial intramedullary nail extraction. The physician indicates that the incisions have healed well and there is no drainage noted. It is noted that the injured worker is anxious to proceed with knee replacement surgery. The medical records also indicate worsening of the activities of daily living. Per the treating physician report dated 7-8-15 the work status is permanent and stationary. The physical exam dated 7-10-15 reveals that the exam of the left knee shows well healed scars and no evidence of infection. The physician notes that there is still thickening of the distal interlock scar, but no tenderness. The left knee exam shows varus alignment, medial joint line tenderness, and palpable osteophytes. The range of motion is noted to be 5 to 115 degrees with crepitus noted. The physician indicates that new weight bearing x-rays "confirm removal of the hardware, no complications, and severe end stage tricompartmental arthritis with bone on bone of the medial compartment, varus deformity, femorotibial shift, and large osteophytes." The medical record dated 7-8-15 the injured worker's weight is 261 pounds and height is 6 feet 1 inch with body mass index (BMI) of 34.43. Treatment to date has included pain medication Norco and Percocet for at least 6 months, left tibial nail hardware removal 6-2-15, acupuncture at least 6 sessions, activity modifications, physical therapy (unknown amount) and other modalities. X-Ray of the left knee dated 7-10-15 reveals moderate to marked medial

compartment osteoarthritis with marked joint space narrowing, and mild to moderate lateral and patellofemoral compartment osteoarthritis which is unchanged. The request for authorization date was 7-15-15 and requested services included Inpatient Left total knee arthroplasty, Associated surgical service: 3 day inpatient stay, Associated surgical service: home health physical therapy x9 visits for the left knee, Post op physical therapy x12 visits for left knee, Associated surgical service: Continuous passive motion rental (unspecified duration), Associated surgical service: Polar care unit rental (unspecified duration), Norco 5-325mg #80, and Percocet 5-325mg #80. The original Utilization review dated 8-19-15 non-certified the request for Inpatient Left total knee arthroplasty and associated surgical service: 3 day inpatient stay as per the ODG guidelines the injured worker does not meet criteria for total knee replacement. The injured worker had 100 degrees of left knee flexion (ODG states must be less than 90 degrees), did not have nighttime joint pain and is morbidly obese with body mass index (BMI) over 35. Therefore, the request is not medically necessary. The request was also non-certified for Associated surgical service: home health physical therapy x9 visits for the left knee, Post op physical therapy x12 visits for left knee, Associated surgical service: Continuous passive motion rental (unspecified duration), and Associated surgical service: Polar care unit rental (unspecified duration) as the request for surgery was non-certified therefore the associated services are not medically necessary. The request for Norco 5-325mg #80 was non-certified as the long term efficacy of opioids for chronic pain remains uncertain and therefore not medically necessary. The request for Percocet 5-325mg #80 was non-certified as opioids are not recommended by the guidelines for first line agents for treatment of pain and prolonged use for the treatment of non-malignant pain can cause addiction, depression and delayed recovery, therefore not medically necessary.

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

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

#### **Inpatient 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 (ODG), Knee & Leg (Acute & Chronic) - 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, records show BMI is 35.8. The guidelines are not met and the request is not medically necessary.

#### **Associated surgical service: 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated surgical service: home health physical therapy x9 visits for the left knee:** 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), Knee & Leg (Acute & Chronic): Home health services.

**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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Post op physical therapy x12 visits for left knee:** 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), Knee & Leg (Acute & Chronic): Physical medicine treatment.

**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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated surgical service: Continuous passive motion rental (unspecified duration):**  
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), Knee & Leg (Acute & Chronic): Continuous passive motion (CPM).

**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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated surgical service: Polar care unit rental (unspecified duration): 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), Knee & Leg (Acute & Chronic): Continuous-flow cryotherapy.

**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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Norco 5/325mg #80: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation ACOEM Chapter 6- Pain, Suffering and the Restoration of Function: Preventing and Managing Chronic Pain and Official Disability Guidelines-Treatment in Workers' Compensation (ODG-TWC), Pain (Chronic): Hydrocodone/Acetaminophen (Vicodin, Lortab) and Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for osteoarthritis.

**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. In this case, there is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity due to medications. Therefore the request is not medically necessary.

**Percocet 5/325mg #80: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation (ODG-TWC), Pain (Chronic): Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for osteoarthritis.

**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. In this case, there is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity due to medications. Therefore, the request is not medically necessary.