

Case Number:	CM15-0076010		
Date Assigned:	04/27/2015	Date of Injury:	02/13/2004
Decision Date:	07/07/2015	UR Denial Date:	03/25/2015
Priority:	Standard	Application Received:	04/21/2015

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: Minnesota, Florida
 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 54-year-old female patient who sustained an industrial injury on 02/13/2014. A primary treating office visit dated 01/19/2015 reported the patient with subjective complaint of neck pain that radiates in the shoulder accompanied with numbness in the upper extremities; along with frequent headaches. In addition, she is with wrist pain and mid-back pain. The lower back pain has increased with radiating pain into the bilateral hips and buttocks. The following diagnoses are applied: osteoarthritis bilateral knees; bilateral medial meniscus tears; anterior cruciate ligament injury, left knee; musculoligamentous sprain lumbar spine with lower extremity radiculitis; disc bulges; musculoligamentous sprain cervical spine with upper extremity radiculitis; disc protrusion; musculoligamentous sprain of thoracic spine; status post arthroscopy, right knee; right shoulder rotator cuff tear; status post right shoulder arthroscopy and open rotator cuff repair, acromioclavicular joint osteoarthritis, bilateral shoulders; tendinitis, bilateral shoulders; capsulitis, bilateral shoulders; status post arthroscopy left knee; recurrent tear medial meniscus, left knee; carpal tunnel syndrome, bilateral wrists; head injury; status post attempted repair of cystocele, retrocele; fractured left metatarsal, healed. The plan of care involved: pending urology consultation, recommending left total knee replacement.

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 (ODG), Indications for Surgery.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Knee, Topic: Total Knee arthroplasty.

Decision rationale: The primary treating physician's progress report dated 1/19/2015 is noted. The subjective complaints at that time included neck pain radiating to the shoulder, numbness in the upper extremities, frequent headaches, right shoulder pain, wrist pain with numbness in the hands at night and weakness of grip, mid back pain with popping, and low back pain with radiating pain in the hips and buttocks, numbness and tingling in the legs into the toes, knee pain with popping and giving out. The objective findings included tenderness over the supraspinatus, right shoulder. Examination findings pertaining to the knees are not reported. The diagnosis was osteoarthritis, bilateral knees, tear medial meniscus, bilateral knees, anterior cruciate ligament injury, left knee and multiple other diagnoses pertaining to other body parts. The injured worker was status post arthroscopy left knee with partial medial meniscectomy, Chondroplasty, and debridement (9/8/2004), the notes also indicate that an AME recommended total knee arthroplasty of the left knee. The notes referred to an MRI scan of the left knee performed in 2007 which showed medial compartment and proximal tibial osteoarthritis. The notes do not refer to the lateral compartment or the patellofemoral joint. No radiology reports are submitted. The next progress report is dated 3/2/2015. The notes document pain in both knees with popping and giving out. Pain is also reported in multiple other body parts. The objective findings included a body weight of 194 pounds but do not make any reference to knee examination. The diagnoses remained the same. A prior progress note dated 11/17/2014 is also submitted. Reference is made to non-certification of the total knee arthroplasty request. An AME dated May 8, 2014 is noted. The radiology report pertaining to the left knee dated 10/2/2009 is unofficially reported to show moderate degenerative joint disease on the medial side. Reference is made to an MRI scan of the left knee dated August 2, 2013 which showed degenerative changes of all joints. There was narrowing of the medial compartment but the MRI does not refer to the other compartments. A moderate to large joint effusion was noted with poor definition of posterior horn of medial meniscus and oblique tear of the undersurface of posterior horn of lateral meniscus. The anterior cruciate ligament was not clearly defined. The ODG indications for a total knee arthroplasty include involvement of 2 of the 3 compartments, evidence of conservative care with medication, exercise therapy such as supervised physical therapy or home rehabilitation exercises, and Viscosupplementation or corticosteroid injections plus subjective clinical findings of limited range of motion with flexion less than 90 degrees and nighttime joint pain and no relief with conservative care and documentation of functional limitations demonstrating necessity of intervention plus objective clinical findings of age over 50 and body mass index of less than 40 plus evidence of imaging clinical findings of osteoarthritis on standing x-rays documenting significant loss of chondral clear space in at least one of the 3 compartments with varus or valgus deformity an indication with additional strength or previous arthroscopy documenting advanced chondral erosion or exposed bone. In this case the documentation submitted is clearly not complete. No radiology reports documenting

osteoarthritis in 2 of the 3 compartments with severe changes in at least one compartment are submitted. The body mass index is not known. Range of motion is not known. Evidence of a nonoperative treatment program with exercise rehabilitation, corticosteroid injections or Viscosupplementation is not submitted. In the absence of such guideline necessitated documentation, the request for a total knee arthroplasty is not supported and the medical necessity cannot be determined.

Housekeeping for Laundry one to two times per week: 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 ODG: Section: Knee, Topic: Knee joint replacement.

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

Housekeeping for Personal care two to three times per week: 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 ODG: Section: Knee, Topic: Knee joint replacement.

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

Pain Management Consultation: Overturned

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 ODG: Section: Pain, Topic: Office Visits.

Decision rationale: ODG guidelines recommend office visits to the offices of medical providers as deemed necessary. Documentation indicates a chronic pain syndrome. As such the request for a pain management consultation is appropriate and medically necessary.

MRI of the Right Shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 207 and 208.

Decision rationale: California MTUS guidelines indicate the specialized imaging studies of the shoulder are not recommended unless a 4-6 week period of conservative care and observation fails to improve symptoms. The documentation provided does not indicate recent physical therapy or corticosteroid injections into the subacromial space. The injured worker had undergone an open rotator cuff repair of the right shoulder in 2006. Furthermore, 2 prior MRI scans of the shoulder had documented rotator cuff tears. A recent physical examination documenting shoulder range of motion and specific findings of an orthopedic examination of the right shoulder has not been submitted. As such, a repeat MRI scan of the shoulder is not medically necessary.