

Case Number:	CM15-0093444		
Date Assigned:	05/19/2015	Date of Injury:	12/29/1999
Decision Date:	08/18/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/14/2015

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
 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 56 year old male, who sustained an industrial injury on 12/29/99. The injured worker has complaints of neck pain, left and right shoulder pain, low back pain and both wrist and both knee pain. The injured worker reports that his knees have pain all the time, with popping clicking and giving out left worse than right. The documentation noted there is increased pain with range of motion and activity and there is tenderness over supraspinatus, deltoid, coracoid and bicipital groove and bilateral shoulders. The diagnoses have included laxity tear anterior cruciate ligament bilateral knees, 12 probable injury tibial lateral ligament, left knee; sprain cervical spine; sprain lumbar spine and tendinitis, bilateral shoulders. Treatment to date has included Norco and Tramadol; magnetic resonance imaging (MRI) of the cervical spine on 2/4/14 showed disc bulges at C3-4, 1-2 millimeter C5-6, 3-4 millimeter and C6-7 3-4 millimeter; magnetic resonance imaging (MRI) of the left knee on 2/19/15 showed findings suggestive of sequelae of remote injury of the tibial collateral ligament, tri-compartmental articular cartilage loss, most pronounced within the lateral femorotibial compartment, mild lateral patellar subluxation and findings are consistent with sequelae of remote Osgood-Schlatter disease; pain management treatment and injections. Exam note 3/2/15 demonstrates range of motion of the knee from 0-110 degrees with an antalgic gait on the left. Positive McMurray's is noted on the left knee with medial tenderness and crepitus. The request was for left knee arthroplasty; pre-operative chest X-ray; per-operative labs; rental of cooling unit; post-operative rental of 1 transcutaneous electrical nerve stimulation unit for two weeks, and post-operative physical therapy for the left knee, quantity 8 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left knee arthroplasty: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): s 343-344. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (Acute and Chronic), Diagnostic Arthroscopy. (2015).

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

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 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. The clinical information submitted demonstrates insufficient evidence to support a knee arthroplasty in this patient. There is no documentation from the exam notes from 3/2/15 of increased pain with initiation of activity or weight bearing. There are no records in the chart documenting when physical therapy began or how many visits were attempted. There is no evidence in the cited examination notes of limited range of motion less than 90 degrees. There is no formal weight bearing radiographic report of degree of osteoarthritis. Therefore the guideline criteria have not been met and the request is not medically necessary.

Pre-operative chest X-ray: 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 and Chronic), X-Ray (2014).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Preoperative testing.

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

Pre-operative labs: 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, Low Back, Preoperative testing.

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

Rental of cooling unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (Acute and Chronic, Continuous-flow cryotherapy). (2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee and Leg, Continuous flow cryotherapy.

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

Post-operative rental of 1 Transcutaneous Electrical Nerve Stimulation (TENS) unit for two weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Home Unit.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): s 113-114.

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

Post Operative physical therapy for the left knee, Quantity: 8.00 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

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