

<b>Case Number:</b>	CM15-0094074		
<b>Date Assigned:</b>	05/20/2015	<b>Date of Injury:</b>	02/05/2008
<b>Decision Date:</b>	06/30/2015	<b>UR Denial Date:</b>	04/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/15/2015

### 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: Illinois, California, Texas  
 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 59-year-old male who sustained an industrial injury on 02/05/2008. Injury occurred when he was pushing a piece of asphalt into the bucket of a backhoe. Past surgical history was reported positive for left total knee arthroplasty with revisions, with the last surgery in 2010. The 2/06/13 left knee CT scan impression documented the left total knee prosthesis was in expected position without evidence to suggest loosening or infection. There was some ossification near the tibial tuberosity just thought to represent some heterotypic bone formation related to previous surgery, which may be the area that was abnormal on the outside nuclear medicine study. There was a small joint effusion in the suprapatellar bursa. The 3/19/15 treating physician report cites ongoing constant slight pain in both knees. Pain was grade 3-4/10 without medication and 1-2/10 with medications. There was frequent, moderate numbness in his left foot and occasional minimal tingling in his hands. Left knee exam documented the incision as clean and dry with range of motion -5 to 110 degrees. Both knees were reported stable in all planes. Right knee range of motion was reported as painful. The diagnosis included left replaced knee joint, mechanical complications of the left prosthetic joint implant, malalignment of the left patella, and right knee osteoarthritis. Authorization was request for left total knee arthroscopy, debridement and synovectomy, postoperative physical therapy 3 times a week for 4 weeks, preoperative clearance, and preoperative labs and EKG, chest x-ray, CBC, BMP, PT, PTT, UA. The 4/16/15 utilization review non-certified the left knee arthroscopy, debridement and synovectomy as there was no clinical evidence of significant abnormality in the submitted records. Imaging was 26 months old with no evidence of significant pathology, and there was no rationale relative to what the knee problem was and what arthroscopy was expected to

accomplish. The 4/16/15 progress report cited frequent moderate bilateral knee pain that was grade 45/10 without medication and 2/10 with medication. There was constant moderate numbness in the hands and feet. Otherwise, the report was unchanged relative to the 3/19/15 progress report.

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

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

#### **Left Total Knee Arthroscopy, Debridement and Synovectomy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Klinger HM, Baums MH, Spahn G, Ernstberger T. A study of effectiveness of knee arthroscopy after knee arthroplasty. Arthroscopy. 2005 Jun; 21(6):731-8. Fehring TK.

**Decision rationale:** The California MTUS guidelines state that surgical consideration may be indicated for patients who have activity limitation for more than one month and failure of exercise programs to increase range of motion and strength of the musculature around the knee. The MTUS and the Official Disability Guidelines do not specifically address the use of arthroscopy or synovectomy following total knee arthroplasty. The National Guidelines Clearinghouse was referenced. Peer-reviewed literature supports the use of arthroscopic treatment of painful knee arthroplasty with expectations for improvement in function, decrease in pain, and improvement in knee scores for most patients. Guideline criteria have not been met. This injured worker presents with bilateral knee pain and numbness in the hands and feet. Clinical exam documented limited range of motion to -5 to 110 degrees with no instability. Functional assessment was not documented. The most recent imaging did not evidence a surgical lesion or prosthetic failure. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There is no rationale in the submitted records to support the medical necessity of this surgery. Therefore, this request is not medically necessary.

#### **Preoperative Clearance: 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

#### **Preoperative Labs: CBC, BMP, PT/PTT and UA: 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Postoperative Physical Therapy (12-sessions, 3 times a week for 4 weeks): 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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

**Preoperative Chest X-Ray: 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.