

<b>Case Number:</b>	CM15-0097646		
<b>Date Assigned:</b>	05/28/2015	<b>Date of Injury:</b>	04/17/2013
<b>Decision Date:</b>	07/03/2015	<b>UR Denial Date:</b>	05/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/20/2015

### 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 56-year-old male who sustained an industrial injury on 4/17/13. The mechanism of injury was not documented. Past surgical history was positive for left knee arthroscopic partial medial and lateral meniscectomy as well as chondroplasties for chondrocalcinosis and grade 3 articular changes on 1/29/14. The 2/12/15 treating physician report cited grade 6/10 bilateral knee pain. Medications were reported helpful in reducing pain and improving function. Physical exam documented medial and lateral joint line tenderness, crepitance with range of motion assessment, extension -10 degrees and flexion 80 degrees with pain. The diagnosis was left knee osteoarthopathy. The series of 3 viscosupplementation of the left knee continued to facilitate diminution of pain and improve tolerance to activity. The injured worker desired to avoid further aggressive options. The treatment plan recommended a right knee hinged brace and prescribed hydrocodone, naproxen, pantoprazole, and cyclobenzaprine. On 5/14/15, authorization was requested for left total knee replacement, surgical assistant, pre op EKG, labs, history and physical, cardiology clearance, and post-op home physical therapy 3 times a week for 2 weeks, followed by outside physical therapy 3 times per week for 4 weeks. No additional information was submitted for review. The 5/20/15 utilization review non-certified the left total knee replacement and associated surgical requests as there was no summarization of prior treatment protocols/modalities and outcomes, no documentation of body mass index and tobacco use history, no recent in-depth knee exam, and no results of standing weight bearing films or prior arthroscopic reports.

## 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), Knee & Leg (updated 05/05/15), Online Version 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 and Leg: Knee joint replacement.

**Decision rationale:** The California MTUS does not provide recommendations for total knee arthroplasty. The Official Disability Guidelines recommend total knee replacement when surgical indications are met. Specific criteria for knee joint replacement include exercise and medications or injections, limited range of motion (less than 90 degrees), night-time joint pain, no pain relief with conservative care, documentation of functional limitations, age greater than 50 years, a body mass index (BMI) less than 40, and imaging findings of osteoarthritis on standing x-rays. Guideline criteria have not been met. This injured worker presents with grade 6/10 bilateral knee pain. Clinical exam findings do not specify the laterality of findings. There was limited range of motion with crepitus. There was no discussion of functional status. There was no documentation of a current body mass index. The injured worker was diagnosed with left knee osteoarthopathy but there was no discussion of standing x-rays findings or prior operative findings. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including exercise, and failure has not been submitted. Therefore, this request is not medically necessary.

### **Surgical Assistant:** 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), Low Back (updated version), Surgical assistant.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee Schedule: Assistant Surgeons, <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

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

### **Pre-op 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:** As the surgical request is not supported, this request is not medically necessary.

**Post-op Home Physical Therapy 3x a week for 2 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

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

**Pre-op labs:** 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.

**Pre-op history and physical:** 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.

**Pre-op cardiology 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.

**Outside physical therapy 3 x a week for 4 weeks after home therapy is completed:** 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.