

Case Number:	CM14-0122953		
Date Assigned:	09/16/2014	Date of Injury:	12/29/2008
Decision Date:	08/18/2015	UR Denial Date:	07/31/2014
Priority:	Standard	Application Received:	08/04/2014

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:

This injured worker is a 51-year-old female who sustained an industrial injury on 12/29/08, relative to a trip and fall. Past surgical history was positive for 3 right knee arthroscopic surgeries and 2 left knee arthroscopic surgeries. Past medical history was positive for hypertension and hypothyroidism. The 5/5/14 treating physician progress report documented that x-rays of the bilateral knees (3 views each) and tibias (2 views each) were obtained and showed evidence of a tibial tubercle elevation procedure in the right knee, and tricompartmental osteoarthritis in both knees. Knee range of motion was documented as 0-135 degrees bilaterally. The 5/7/14 treating physician report cited continued bilateral knee pain radiating down the shins with ankle swelling. The right knee was reported the most bothersome and recently gave out. Physical exam documented limited range of motion, stiffness, swelling, and bilateral medial tenderness. A corticosteroid injection was performed to the right knee. Progress reports submitted by the treating physician from 6/16/14 through 7/30/14 cited persistent and severe knee pain and limping. Physical exam documented anterior knee tenderness. The treatment plan included left knee arthrotomy with patellofemoral arthroplasty with assistant surgeon, 7-day use of a cold therapy unit, and 12 post-op physical therapy sessions. Authorization was also requested for 17-day use of a continuous passive motion (CPM) device, x-rays of the right knee (3 views), x-rays of the right tibia (2 views), and x-rays of the left tibia (2 views). The 7/31/14 utilization review certified the requests for left knee patellofemoral arthroplasty with assistant surgeon, cold therapy unit, and physical therapy. The request for 17-day use of a CPM device was non-certified, as guidelines do not support the use of CPM in unicompartmental knee replacement.

The request for x-rays of the right knee and bilateral tibia was non-certified as there was no indication for additional imaging given previous imaging demonstrating patellofemoral joint osteoarthritis and no rationale to support further imaging of the tibia.

IMR ISSUES, DECISIONS AND RATIONALES

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

17 day use of a continuous passive motion device: 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 and Leg: Continuous passive motion (CPM).

Decision rationale: The California MTUS does not provide recommendations for this device following knee replacement. The Official Disability Guidelines state that the use of a continuous passive motion device may be considered medically necessary in the acute hospital setting for 4 to 10 day (no more than 21 days) following total knee replacement and for home use up to 17 days while the patient at risk of a stiff knee is immobile or unable to bear weight following a primary or revision total knee arthroplasty. Guideline criteria have not been met. There is no documentation that this injured worker would be immobile or unable to bear weight following the certified partial knee replacement. Pre-operative range of motion was documented as functional. There is no compelling rationale to support the medical necessity of post-operative CPM device in the absence of guideline support following unicompartmental knee replacement. Therefore, this request is not medically necessary.

X-ray of the right knee (3 views): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Radiography (x-rays).

Decision rationale: The California MTUS guidelines do not recommend routine radiographs for most knee complaints or injuries. The Official Disability Guidelines recommend an initial knee/leg x-ray study for patients with history of acute trauma. An initial exam is recommended for non-traumatic knee pain with patellofemoral symptoms. Guideline criteria have not been met. Records indicate that x-rays of both knees were performed on 5/5/14. There is no compelling reason submitted to support the medical necessity of repeat radiographs for this patient with

documented osteoarthritis and planned partial knee replacement. Therefore, this request is not medically necessary.

X-ray of the right tibia (2 views): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Radiography (x-rays).

Decision rationale: The California MTUS guidelines do not recommend routine radiographs for lower extremity complaints or injuries. The Official Disability Guidelines recommend an initial knee/leg x-ray study for patients with history of acute trauma. An initial exam is recommended for non-traumatic leg/knee pain. Guideline criteria have not been met. There is no compelling reason submitted to support the medical necessity of separate tibial x-rays for this injured worker. Bilateral tibial radiographs were obtained on 5/5/14 and documented knee osteoarthritis. There are no red flag findings relative to the tibia to support this request for repeated x-rays. Therefore, this request is not medically necessary.

X-ray of the left tibia (2 views): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Radiography (x-rays).

Decision rationale: The California MTUS guidelines do not recommend routine radiographs for lower extremity complaints or injuries. The Official Disability Guidelines recommend an initial knee/leg x-ray study for patients with history of acute trauma. An initial exam is recommended for non-traumatic leg/knee pain. Guideline criteria have not been met. There is no compelling reason submitted to support the medical necessity of separate tibial x-rays for this injured worker. Bilateral tibial radiographs were obtained on 5/5/14 and documented knee osteoarthritis. There are no red flag findings relative to the tibia to support this request for repeated x-rays. Therefore, this request is not medically necessary.