

<b>Case Number:</b>	CM13-0059279		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	11/24/2009
<b>Decision Date:</b>	05/07/2014	<b>UR Denial Date:</b>	11/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 70-year-old male who reported an injury on 11/24/2009. The mechanism of injury was not stated. Current diagnosis includes retained antibiotic cement spacer of the right knee. The injured worker was evaluated on 11/12/2013. The injured worker was status post removal of an infected knee replacement and placement of antibiotic cement spacer. Physical examination revealed a well-healed anterior incision without any swelling and intact sensation. X-rays obtained in the office on that date indicated retained antibiotic cement spacer in the right knee. Treatment recommendations included a right knee revision replacement with removal of antibiotic cement spacer. A request for authorization was then submitted on 11/18/2013 for a revision right total knee arthroplasty with in home RN medication intake, TED hose stockings, a 21-day rental of a CPM machine, and cold therapy unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**" Associated surgical service" PREOPERATIVE MEDICAL CLEARANCE:** 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG).

**Decision rationale:** The Official Disability Guidelines state the decision to order preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. There is no documentation of a significant medical history or comorbidities that would warrant the need for preoperative medical clearance. Therefore, the medical necessity has not been established. As such, the request for PREOPERATIVE MEDICAL CLEARANCE is non-certified.

**IN-HOME NURSE MEDICATION INTAKE/EVALUATION/VITALS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines.

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

**Decision rationale:** The California MTUS Guidelines state home health services are recommended only for otherwise recommended medical treatment for patients who are homebound on a part time or intermittent basis, generally up to no more than 35 hours per week. There is no indication that this injured worker will be homebound following surgical intervention. There was also no frequency or total duration of treatment provided in the request. Based on the clinical information received and the California MTUS Guidelines, the request for IN-HOME NURSE MEDICATION INTAKE/EVALUATION/VITALS is non-certified.

**TED HOSE STOCKINGS (TWO PAIRS):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee & Leg Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) KNEE & LEG CHAPTER, VENOUS THROMBOSIS

**Decision rationale:** The Official Disability Guidelines recommend identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures such as consideration for anticoagulation therapy. Aspirin may be the most effective choice to prevent pulmonary embolism and venous thromboembolism in patients undergoing orthopedic surgery. As per the documentation submitted, there is no indication that this injured worker is at high risk of developing a venous thrombosis. There is no mention of a contraindication to oral anticoagulation therapy. The medical necessity for two pair of stockings has not been established. Based on the clinical information received, the request is non-certified.

**THE PURCHASE 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).

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

**Decision rationale:** The Official Disability Guidelines state continuous passive motion is recommended for specific indications. In the acute hospital setting, postoperative use may be considered medically necessary for 4 to 10 consecutive days. CPM is then recommended for home use, up to 17 days after surgery. The current request for THE PURCHASE OF A CONTINUOUS PASSIVE MOTION DEVICE exceeds Guideline recommendations. Therefore, the request is non-certified.

**THE PURCHASE OF A COLD THERAPY UNIT:** 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).

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

**Decision rationale:** The Official Disability Guidelines state continuous flow cryotherapy is recommended as an option after surgery. Postoperative use generally may be up to 7 days, including home use. The current request for THE PURCHASE OF A COLD THERAPY UNIT exceeds Guideline recommendations. Therefore, the request is non-certified.