

<b>Case Number:</b>	CM14-0014396		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	08/17/1999
<b>Decision Date:</b>	06/27/2014	<b>UR Denial Date:</b>	01/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/05/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in Texas. 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 female who reported an injury on 08/17/1999 with the mechanism of injury not cited within the documentation provided. In the clinical note dated 12/03/2013, it was annotated that the injured worker was status post right total hip using a custom PMI-PPI implant. It was noted that the injured worker had developed a perioperative fracture of her distal femur which was transverse low at the supracondylar junction. It was treated with a brace rather than surgery. This treatment was based on the fact that the injured worker had postoperatively had severe depression and was not eating well and was severely malnourished. It was noted that the injured worker had a lot of issues with pain and mobilization and therefore, the physician felt that proceeding with a plate construct for a nondisplaced fracture in an osteoporotic femur would be risky and if the entire construct became infected, it would basically doom her to a potential amputation. The physical examination revealed that the injured worker was partial weight-bearing, heel to toe, with the use of 2 crutches. The physical examination of the right knee revealed a resting valgus alignment of 7 degrees, with puffiness in the supracondylar area as expected with a fracture. The range of motion was noted as 0 to 90 degrees, with a lag and quad firing quivering. It was noted that there was irritability over the patellofemoral joint with palpation and with flexion. It was also noted that the knee felt stable with varus-valgus stressing. The x-rays to the right knee showed on the anteroposterior view, a transverse fracture at the low supracondylar area and healing callus being evidence. It showed overall good alignment, mild irregularity to joint spaces, and no evidence of avascular necrosis. The lateral view of the right knee showed inferior displacement of the femur on the tibia by 10 to 15% with surrounding callus. The diagnoses included complex revision of the right total hip with custom PMI-PPI triflange implant, revision of the right total hip with prior history of multiple dislocations currently stable, supracondylar transverse fracture of the right knee with healing

callus and residual pain. The discussion for the treatment plan included options of nonoperative treatment with continued bracing and progressive weight-bearing on the right knee, ORIF with a reconstruction metal plate, and possible iliac crest bone grafting if needed, and reconstruction with the revision knee prosthesis with a revision femoral stem and tibial stem. It was documented that the physician recommended a 1-time reconstruction using a revision knee system to allow immediate mobilization. It was also noted that the injured worker did not want to proceed with any further nonoperative management. The request for authorization for a three day inpatient stay, 12 lead electrocardiogram (EKG), and 2 view chest xray for the diagnosis of supracondylin femur fracture right knee, and degenerative joint disease of the right knee for the procedure of right total knee arthroplasty complex with revision of constrained knee was submitted on 12/18/2013.

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

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

#### **THREE DAY INPATIENT STAY: 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 (ODG) Knee and Leg (acute and chronic), hospital length of stay (LOS).

**Decision rationale:** The recommended hospital length of stay in the ODG Guidelines state that knee replacement has a median of 3 days and a mean of 3.4 days. In the clinical notes provided for review, it was not indicated that the recommended knee surgery had been authorized to support the necessity of the requested 3 day inpatient stay. Therefore, the request for 3 day inpatient stay is non-certified.

#### **12 LEAD ELECTROCARDIOGRAM (EKG): 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 (ODG) Low back, preoperative electrocardiogram (ECG).

**Decision rationale:** The request for 12 lead electrocardiogram (EKG) is non-certified. The Official Disability Guidelines (ODG) state that an electrocardiogram (ECG) is recommended for patients undergoing high risk surgery, and those undergoing intermediate risk surgery who have additional risk factors. Injured workers undergoing low risk surgery do not require electrocardiography. Injured workers with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Preoperative ECGs in injured workers without known risk factors for coronary disease, regardless of age,

would not be necessary. Preoperative and postoperative resting 12 lead EKGs are not indicated in asymptomatic persons undergoing low risk surgical procedures. Low risk procedures (with reported cardiac risk generally less than 1%) include endoscopic procedures; superficial procedures; cataracts surgery; breast surgery; and ambulatory surgery. An ECG within 30 days of surgery is adequate for those with stable disease in whom a preoperative ECG is indicated. In the clinical notes provided for review, it was noted that the injured worker had developed a DVT postoperative of the right hip; however, this was being treated with Coumadin. There was also a lack of documentation of the injured worker indicating any other physiological evidence of cardiological issues. Furthermore, the documentation provided lacked the indication of the surgical intervention of the right knee had been authorized. Therefore, the request for 12 lead electrocardiogram (EKG) is not medically necessary.

**TWO VIEW 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back pain, preoperative testing general.

**Decision rationale:** The request for 2 view chest x-ray is non-certified. The Official Disability Guidelines (ODG) states that chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the result would change perioperative management. Patients in their usual state of health who are undergoing cataract surgery do not require preoperative testing. Routine preoperative tests are defined as those done in the absence of any specific clinical indication or purpose and typically include a panel of blood tests, urine tests, chest radiography, and an electrocardiogram. These tests are performed to find latent abnormalities, such as anemia or silent heart disease that could impact how, when, or whether the planned surgical procedure and concomitant anesthesia are performed. In the clinical notes provided for review, it was noted that the injured worker had been treated for a DVT below knee with Coumadin. However, the documentation lacked the rationale for the indication of a 2 view chest x-ray since there was no documentation of cardiological issues. Furthermore, the request for the surgical intervention was not noted to be authorized. Therefore, the request for 2 view chest x-ray is not medically necessary.