

<b>Case Number:</b>	CM14-0127350		
<b>Date Assigned:</b>	08/15/2014	<b>Date of Injury:</b>	07/30/2002
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	07/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/12/2014

### 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 Orthopedic Surgery 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:

This is a 52-year-old who sustained a vocational injury on 07/03/02. The medical records provided for review document that prior to the vocational injury the claimant underwent left knee arthroscopic medial meniscectomy in 1990. Subsequent to the date of the vocational injury, the claimant underwent arthroscopic medial meniscectomy and chondroplasty and medial plica resection in March of 2006, and arthroscopic partial medial meniscectomy and chondroplasty in August of 2008. The office note dated 06/24/14 documented the claimant's diagnosis as left lower extremity unspecified disorder of the joint, pain in the left knee which has persisted and unspecified internal derangement of the left knee. At that time, the claimant's height was noted to be 5'9" and weight was 250 pounds giving him an approximate BMI of 36.9. Conservative treatment was documented to include pain management that was working fairly well despite persistent pain. He has received an unweighted brace that he was using at night. The claimant asked to proceed with a full left knee replacement. On exam, he was wearing hinged knee braces on both knees. In regards to the left knee, there was gross crepitation and tenderness along the patellofemoral ligament on the medial aspect more than the lateral. He walked with somewhat of an antalgic gait. Conservative treatment to date has included medications, home exercises, viscosupplementation, bracing and physical therapy. The report of a previous utilization review determination noted that CT left knee arthrogram performed in January of 2008 showed minimal medial joint space narrowing. The current request was for a left total knee replacement and accompanying preoperative laboratory evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Complete blood count, Hepatic panel, and a chem 7 blood test.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment for Workers Compensation, online edition. Low Back - Preoperative testing.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004); Chapter 7, page 127 Introduction The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. An independent medical assessment also may be useful in avoiding potential conflict(s) of interest when analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification. When a physician is responsible for performing an isolated assessment of an examinee's health or disability for an employer, business, or insurer, a limited examinee-physician relationship should be considered to exist. A referral may be for: -Consultation: To aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. -Independent Medical Examination (IME): To provide medicolegal documentation of fact, analysis, and well-reasoned opinion, sometimes including analysis of causality. An IME differs from consultation in that there is no doctor-patient relationship established and medical care is not provided. It may be a means of medical clarification or adjudication in which the physician draws conclusions regarding diagnosis, clinical status, causation, work-relatedness, testing and treatment efficacy and requirements, physical capacities, impairment, and prognosis based on available information. The evaluations must be independent, impartial, and without bias. The client often may be the employer, insurer, state authority, or attorney. Citation(s): Harris J, Occupational Medicine Practice Guidelines, 2nd Edition (2004) - pp. 127 Hegmann K, Occupational Medicine Practice Guidelines, 2nd Ed (2008 Revision) - pp. 503.

**Decision rationale:** The proposed left total knee replacement is not recommended as medically necessary. Therefore, the request for complete blood count, hepatic panel and chem 7 blood test is not medically necessary.

**Total left 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, Knee and Leg Chapter, Indications for surgery, knee arthroplasty.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Knee & Leg chapter: Knee joint replacement Recommended as indicated below. Total hip and total knee arthroplasties are well accepted as reliable and suitable surgical procedures to return

patients to function. The most common diagnosis is osteoarthritis. Overall, total knee arthroplasties were found to be quite effective in terms of improvement in health-related quality-of-life dimensions, with the occasional exception of the social dimension. Age was not found to be an obstacle to effective surgery, and men seemed to benefit more from the intervention than did women. (Ethgen, 2004) Total knee arthroplasty was found to be associated with substantial functional improvement. (Kane, 2005) Navigated knee replacement provides few advantages over conventional surgery on the basis of radiographic end points. (Bathis, 2006) (Bauwens, 2007) The majority of patients who undergo total joint replacement are able to maintain a moderate level of physical activity, and some maintain very high activity levels. (Bauman, 2007) Functional exercises after hospital discharge for total knee arthroplasty result in a small to moderate short-term, but not long-term, benefit. In the short term physical therapy interventions with exercises based on functional activities may be more effective after total knee arthroplasty than traditional exercise programs, which concentrate on isometric muscle exercises and exercises to increase range of motion in the joint. (Lowe, 2007) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense physical therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. (Larsen, 2008) In this RCT, perioperative celecoxib (Celebrex) significantly improved postoperative resting pain scores at 48 and 72 hrs, opioid consumption, and active ROM in the first three days after total knee arthroplasty, without increasing the risks of bleeding. The study group received a single 400 mg dose of celecoxib, one hour before surgery, and 200 mg of celecoxib every 12 hours for five days. (Huang, 2008) Total knee arthroplasty (TKA) not only improves knee mobility in older patients with severe osteoarthritis of the knee, it actually improves the overall level of physical functioning. Levels of physical impairment were assessed with three tools: the Nagi Disability Scale, the Instrumental Activities of Daily Living Scale (IADL) and the Activities of Daily Living (ADL) Scale. Tasks on the Nagi Disability Scale involve the highest level of physical functioning, the IADL an intermediate level, and the ADL Scale involves the most basic levels. Statistically significant average treatment effects for TKA were observed for one or more tasks for each measure of physical functioning. The improvements after TKA were "sizeable" on all three scales, while the no-treatment group

**Decision rationale:** The California ACOEM Guidelines provide guidelines for surgical indications but do not provide criteria pertinent to total knee replacement. The Official Disability Guidelines recommend that prior to considering total knee replacement, the claimant should be over 50 years of age and have a body mass index of less than 35 because an increased BMI poses elevated risks for postoperative complications. ODG also recommend that there should be imaging, clinical findings or intraoperative photographs and documentation supporting that the claimant has end stage arthritis in at least one of the three compartments with varus or valgus deformity, or significant advanced chondral erosion, or exposed bone consistent with end stage chondral defects. Despite the fact that the claimant has attempted multiple modalities and conservative treatment options, there is a lack of documentation that this claimant has significant abnormal objective findings on physical examination establishing the medical necessity of the requested procedure. More importantly, the claimant's BMI is noted to be greater than 35 and he appears to have put on weight at each follow up visit over the past year. Documentation also fails to establish that there is a recent diagnostic study confirming end stage arthritis in at least one compartment, which would be essential prior to considering total knee replacement as

medically necessary. Therefore, based on the documentation presented for review and in accordance with the Official Disability Guidelines, the request for a left total knee replacement is not medically necessary.