

<b>Case Number:</b>	CM14-0061287		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	01/21/2013
<b>Decision Date:</b>	08/08/2014	<b>UR Denial Date:</b>	04/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/02/2014

### 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 75-year-old male janitor sustained an industrial injury on 1/21/13. The mechanism of injury was not documented, although there was a history of repetitive slip and falls. The 2/28/13 left knee MRI impression documented osteoarthritic changes of the knee joints, severe in the medial compartment and mild in the patellofemoral joint and lateral compartments. There were two spherical 2x3 cm masses in the popliteal fossa. There was a grade III/IV stellate tear posterior horn and body medial meniscus, joint effusion, and a large popliteal cyst. Conservative treatment to the knee had included cortisone injections, regular home exercise, anti-inflammatory medications, and activity modification. Records did not indicate that the patient was obese. Weight was documented as 185 pounds with no height provided. The 1/17/14 orthopedic consult report cited exam findings of positive varus thrust, 10 degrees of varus, range of motion 5-115 degrees, and 1+ opening to varus and valgus stress with a stable end point. There was medial and lateral joint line tenderness, trace effusion, and patellofemoral crepitus. The diagnosis was end-stage osteoarthritis with marked varus malalignment. A total knee arthroplasty was recommended. The 3/25/14 treating physician progress report cited on-going left knee pain, unrelieved by medications. Physical exam documented advanced deformity in the left knee with patellofemoral crepitus and decreased range of motion. There was medial and lateral joint line tenderness and positive effusion. Meniscal evaluation was not possible due to pain and guarding. There was wasting of the left quadriceps and 4/5 global left lower extremity weakness. Gait was antalgic favoring the left leg. The diagnosis was advanced left knee degenerative joint disease. The treatment plan recommended left total knee replacement. The 4/18/14 utilization review denied the request for total knee arthroplasty based on a lack of recent weight bearing x-rays, absence of information to calculate body mass index, and all pre-operative conservative treatment had not been utilized.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Total Knee Arthroplasty left knee: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS ODG, Knee and Leg, 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 (< 90 degrees), nighttime joint pain, no pain relief with conservative care, documentation of functional limitations, age greater than 50 years, a body mass index (BMI) less than 35, and imaging findings of osteoarthritis. Guideline criteria have been met. This patient presents with significant left knee pain and functional loss. Clinical exam and imaging findings are consistent with the diagnosis of end-stage osteoarthrosis. Failure of guideline-recommended conservative treatment has been documented. Body mass index is not documented but there is no indication of obesity in any of the reviewed records, weight is noted at 185 pounds. Therefore, this request for left knee total knee arthroplasty is medically necessary.

### **Home Physical Therapy evaluation: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Home Health Services, pg. 51.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services, page(s) 51 Page(s): 51, Postsurgical Treatment Guidelines Page(s): 24.

**Decision rationale:** The California MTUS Post-Surgical Treatment Guidelines for knee arthroplasty suggest a general course of 24 post-operative visits over 10 weeks during the 4-month post-surgical treatment period. Guidelines recommend home health services only for otherwise recommended treatment for patients who are homebound, on a part time or intermittent basis. Guideline criteria have been met. It is reasonable that this patient would be homebound on a part time or intermittent basis following total knee replacement. A home physical therapy evaluation is reasonable and consistent with guidelines. Therefore, this request for home physical therapy evaluation is medically necessary.

### **Cold Therapy 4 weeks: Upheld**

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

**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 flow cryotherapy.

**Decision rationale:** The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous-flow cryotherapy is an option for up to 7 days in the post-operative setting following knee surgery. Under consideration is a request for 4-week use of a cold therapy unit. Although the use of cold therapy during the post-operative period would be appropriate for this patient, there is no compelling reason to support the medical necessity of this request beyond the 7-day guideline recommendation. Therefore, this request for cold therapy for 4 weeks is not medically necessary.

**Continuous Passive Motion (CPM) x6 weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS ODG, Knee and Leg, 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 arthroplasty. The Official Disability Guidelines recommended the use of continuous passive motion (CPM) devices in the home for up to 17 days while patients at risk of a stiff knee are immobile or unable to bear weight following a primary or revision total knee arthroplasty. Under consideration is a request for 6-week home use of a CPM machine. Although the use of CPM during the post-operative period for home use would be appropriate for this patient, there is no compelling reason to support the medical necessity of this request beyond the 17-day guideline recommendation. Therefore, this request for continuous passive motion (CPM) x 6 weeks is not medically necessary.

**3-4 day inpatient:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS ODG, Knee and Leg, Hospital Length of Stay (LOS).

**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, Hospital length of stay (LOS).

**Decision rationale:** The California MTUS does not provide recommendations for hospital length of stay (LOS). The Official Disability Guidelines recommend the median LOS based on type of surgery, or best practice target LOS for cases with no complications. The recommended mean and best practice target for a revision total knee arthroplasty is 4 days. Guideline criteria have been met for inpatient stay up to 4 days, in the absence of complications. Therefore, this request for 3-4 day inpatient stay is medically necessary.