

Case Number:	CM14-0088596		
Date Assigned:	08/08/2014	Date of Injury:	11/30/2007
Decision Date:	01/05/2015	UR Denial Date:	05/19/2014
Priority:	Standard	Application Received:	06/12/2014

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 51 year old male with an 11/30/07 injury date. In a 4/30/14 note, the patient complained of 8/10 right knee pain. Objective findings included right knee flexion to 120 degrees and extension to neutral, tenderness over the medial joint line, instability with varus and valgus stress testing, and 5/5 muscle strength. The provider stated that the patient continues to have a fairly painful and unstable right total knee implant, especially unstable in varus. The patient needs a constrained liner, and therefore, needs a revision knee replacement. This request is unrelated to the patient's previous infection, which has been successfully treated. Right knee x-rays on 9/21/13 showed no fracture, dislocation, foreign body, and positive effusion. Diagnostic impression status post right total knee arthroplasty with unstable implant. Treatment to date includes right total knee arthroplasty (11/16/12), right knee irrigation and debridement for infection (2013), medications, and physical therapy. A UR decision on 5/19/14 denied the request for revision right total knee arthroplasty because there was no documentation of culture results, knee aspiration results, or recent lab and imaging results. The requests for physical therapy, polar care, walker, DVT machine, and topical compounded cream were denied because the associated surgical procedure was not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Revision right total knee arthroplasty: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

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

Decision rationale: CA MTUS does not address this issue. Official Disability Guidelines (ODG) states that revision total knee arthroplasty is an effective procedure for failed knee arthroplasty based on global knee rating scales. It would be recommended for failure of the originally approved arthroplasty. In this case, there is continued knee pain after a 2012 original arthroplasty, gross knee instability, and varus deformity. This instability is most likely related to the previous post-operative infection, which was successfully treated with irrigation, debridement, and antibiotics. Continued knee instability as documented in this case must be addressed surgically and revised. Therefore, the request for revision right total knee arthroplasty is medically necessary.

Post-operative physical therapy 2 x 6 right knee: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter, Physical Medicine Treatment

Decision rationale: CA MTUS does not address this issue. Official Disability Guidelines (ODG) supports 24 physical therapy sessions over 10 weeks after arthroplasty of the knee. The current request for 12 sessions over 6 weeks is allowable under these criteria, and the surgical request was found to be medically necessary. Therefore, the request for postoperative physical therapy 2 x 6 right knee is medically necessary.

Polar care 7 day rental: Overturned

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 Chapter, Continuous-Flow Cryotherapy

Decision rationale: CA MTUS does not address this issue. Official Disability Guidelines (ODG) states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. Given that the associated surgery was found to be medically necessary, a 7-day rental of a cold

therapy unit is appropriate. Therefore, the request for polar care 7-day rental is medically necessary.

Walker: Overturned

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 Chapter, Walking Aids

Decision rationale: CA MTUS does not address this issue. Official Disability Guidelines (ODG) states that walking aids are recommended. Given that the associated surgery was found to be medically necessary, a walker is appropriate. Therefore, the request for walker is medically necessary.

Deep Venous Thrombosis (DVT): Overturned

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), Knee Chapter, Vasopneumatic Devices

Decision rationale: CA MTUS does not address this issue. Official Disability Guidelines (ODG) states that vasopneumatic devices are recommended as an option to reduce edema after acute injury. Vasopneumatic devices apply pressure by special equipment to reduce swelling; or for home-use as an option for the treatment of lymphedema after a four-week trial of conservative medical management that includes exercise, elevation and compression garments. In this case, knee arthroplasty is a high-risk procedure for developing DVT, and the procedure was found to be medically necessary. A deep venous thrombosis (DVT) machine is appropriate postoperatively. Therefore, this request is medically necessary.

Flurbiprofen/cyclobenzaprine/ menthol cream 20% / 10%/ 4% 180gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: An online search has revealed that Fluriflex ointment/cream is a combination of Flurbiprofen/cyclobenzaprine 15/10%. CA MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a

0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. However, this compound contains topical cyclobenzaprine and Flurbiprofen, which are not currently supported by MTUS and Official Disability Guidelines (ODG). Regarding the request, medical necessity was not met. Therefore, the request for Flurbiprofen/cyclobenzaprine/ menthol cream 20% / 10%/ 4% 180gm is not medically necessary.