

Case Number:	CM15-0163638		
Date Assigned:	08/31/2015	Date of Injury:	09/25/2014
Decision Date:	09/30/2015	UR Denial Date:	08/10/2015
Priority:	Standard	Application Received:	08/20/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Oregon, Washington
 Certification(s)/Specialty: Orthopedic Surgery

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 was a 46 year old female, who sustained an industrial injury, September 25, 2014. The injured worker previously received the following treatments Ibuprofen; unloader brace, Viscosupplementation injections, cartilage transplant, and micro-fracture, right knee MRI showed thinning of the medial and patellofemoral compartments and osteochondral lesion in the medial compartment. The injured worker was diagnosed with arthritis of the right knee and right knee medial meniscus tear. According to progress note of August 4, 2015, the injured worker's chief complaint was right knee pain. The physical exam noted the injured worker walked with a moderately antalgic gait from the affected right side with small steps. There was no physical exam completed at this visit. The plan was to go forward with right knee arthroplasty surgery. The treatment plan included continuous range of motion machine, DVT pump, knee stimulator unit and at home physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: CPM unit (in days), QTY: 28: 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) knee.

Decision rationale: CA MTUS/ACOEM is silent on the issue of CPM. According to ODG criteria, CPM is medically necessary postoperatively for 4-10 consecutive days but no more than 21 following total knee arthroplasty. As the guideline criteria have not been met, the determination is for non-certification. The request is not medically necessary.

Associated surgical service: DVT Pump (indefinite use), QTY: 1: 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) Knee and Leg section, Compression Garments.

Decision rationale: CA MTUS/ACOEM is silent on the issue of DVT compression garments. The ODG, Knee and Leg section, Compression Garments, summarizes the recommendations of the American College of Chest Physicians and American Academy of Orthopedic Surgeons. It is recommend to use of mechanical compression devices as an inpatient after all major knee surgeries including total hip and total knee replacements. In this patient, there is no documentation of a history of increased risk of DVT. The AAOS and Chest guidelines do not recommend ongoing use of compression devices once a patient is ambulatory postoperatively. Therefore medical necessity cannot be established and therefore the determinations for non-certification for the requested device. The use of an outpatient pneumatic compression device is not medically necessary as it is not in accordance with nationally accepted standards of medical practice. While the use of a pneumatic compression device is clinically appropriate in an inpatient setting, their utility has not been demonstrated in an outpatient setting once the postoperative total knee arthroplasty patient is ambulatory. There are recommendations from the American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (9th edition) that discuss the prevention of venous thromboembolism in orthopedic surgery patients. One of the recommendations is: "In patients undergoing total hip arthroplasty (THA) or total knee arthroplasty (TKA), we recommend use of one of the following for a minimum of 10 to 14 days rather than no antithrombotic prophylaxis: low-molecular-weight heparin (LMWH), fondaparinux, apixaban, dabigatran, rivaroxaban, low-dose unfractionated heparin (LDUH), adjusted-dose vitamin K antagonist (VKA), aspirin (all Grade 1B), or an intermittent pneumatic compression device (IPCD) (Grade 1C)." There is nothing in the medical record that documents that this patient is intolerant or has a contraindication to: low-molecular-weight heparin, low-dose unfractionated heparin, or adjusted-dose vitamin K antagonist. An additional recommendation from the American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (9th edition) is that: "In patients undergoing major orthopedic surgery, we suggest using dual prophylaxis with an antithrombotic agent and an IPCD during the hospital stay (Grade 2C)." This recommendation states that the use of an intermittent pneumatic compression device is only indicated in the inpatient setting and is not recommended in the

outpatient setting once the patient is ambulatory. The American Academy of Orthopaedic Surgeons has also released their guidelines for deep venous thrombosis prophylaxis in arthroplasty patients. The AAOS has stated: "In the absence of reliable evidence, it is the opinion of this work group that patients undergoing elective hip or knee arthroplasty, and who also have a known bleeding disorder (e.g., hemophilia) and/or active liver disease, use mechanical compressive devices for preventing venous thromboembolism." There is no evidence on the medical record that this patient has a known bleeding disorder and/or active liver disease.

Associated surgical service: Knee Stimulation Unit (indefinite use), QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

Decision rationale: Regarding the Interferential Current Stimulation (ICS), the California MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation, pages 118-119 state, not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. As there is insufficient medical evidence regarding use in this clinical scenario, the determination is for non-certification. The request is not medically necessary.

Associated surgical service: Physical Therapy Sessions in the home, QTY: 9: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Care Page(s): 51.

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, home health services.

Decision rationale: CA MTUS/ACOEM is silent on the issue of home physical therapy. According to ODG, Knee and Leg, home health services including physical therapy are only for medical treatment in patients who are home-bound on a part-time or intermittent basis. Medical treatment does not include homemaker services like shopping, cleaning, laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Home health skilled nursing is recommended for wound care or IV antibiotic administration. There is no evidence in the records from 8/4/15 that the patient is home bound. There is no other substantiating reason why home health physical therapy is required. Therefore determination is for non-certification. The request is not medically necessary.

