

Case Number:	CM15-0024224		
Date Assigned:	02/13/2015	Date of Injury:	02/03/2014
Decision Date:	05/04/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	02/09/2015

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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 63 year old female, who sustained an industrial injury on 2/3/14. She reported bilateral knee injuries. The injured worker was diagnosed as being status post total right knee arthroplasty. Treatment to date has included physical therapy, oral medications and right knee injections. Currently, the injured worker complains of right knee pain. Tenderness is noted to palpation of all three compartments of right knee. The treatment plan consisted of post op physical therapy and game ready unit extension.

IMR ISSUES, DECISIONS AND RATIONALES

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

Game ready unit rental for 30 days: 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), Knee, CPM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Game Ready accelerated recovery system <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, Game Ready accelerated recovery is recommended in case of knee surgery. “Recommended as an option after surgery, but not for nonsurgical treatment. See Continuous-flow cryotherapy. The Game Ready system combines Continuous-flow cryotherapy with the use of vaso-compression. While there are studies on Continuous-flow cryotherapy, there are no published high quality studies on the Game Ready device or any other combined system. However, in a recent yet-to-be-published RCT, patients treated with compressive cryotherapy after ACL reconstruction had better pain relief and less dependence on narcotic use than patients treated with cryotherapy alone. (Waterman, 2011)” The patient underwent a right knee total arthroplasty and a seven day Game Ready is appropriate. Although the patient was diagnosed with state post right knee surgery there is no justification of 30 days Game Ready. There is no controlled studies supporting the use of Game Ready for 30 days after knee surgery. Therefore, the request for Game ready unit rental for 30 days is not medically necessary.

Continuous passive motion (CPM) rental for 30 days: 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), Knee, Game ready accelerated recovery system.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Continuous passive motion (CPM). <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, CPM “Recommended as indicated below, for in-hospital use, or for home use in patients at risk of a stiff knee, based on demonstrated compliance and measured improvements, but the beneficial effects over regular PT may be small. Routine home use of CPM has minimal benefit. Although research suggests that CPM should be implemented in the first rehabilitation phase after surgery, there is substantial debate about the duration of each session and the total period of CPM application. A Cochrane review on this topic concluded that short-term use of CPM leads to greater short-term range of motion. But in a recent RCT results indicated that routine use of prolonged CPM should be reconsidered, since neither long-term effects nor better functional performance was detected. The experimental group received CPM + PT in the home situation for 17 consecutive days after surgery, whereas the usual care group received the same treatment during the in-hospital phase (i.e. about four days), followed by PT alone (usual care) in the first two weeks after hospital discharge. (Lenssen, 2008) Continuous passive motion (CPM) combined with PT, may offer beneficial results compared to PT alone in the short-term rehabilitation following total knee arthroplasty. Results favoring CPM were found for the main comparison of CPM combined with physical therapy (PT) versus PT alone at end of treatment. For the primary outcomes of interest, CPM combined with PT was found to statistically significantly increase active knee flexion and decrease length of stay. CPM was also found to decrease the need for post-operative manipulation. CPM did not significantly improve passive knee flexion and passive or active knee extension. (Milne-Cochrane, 2003) (Kirschner, 2004) (Brosseau, 2004) (Bennett, 2005) (Lenssen, 2006) Continuous passive motion can stimulate chondrocyte production of

proteoglycan 4 (PRG4), a molecule found in synovial fluid with putative lubricating and chondro protective properties. (Nugent-Derfus, 2006) A recent Cochrane review concluded that there is high-quality evidence that continuous passive motion increases passive knee flexion range of motion (mean difference 2 degrees) and active knee flexion range of motion (mean difference 3 degrees), but that these effects are too small to be clinically worthwhile, and there is low-quality evidence that continuous passive motion has no effect on length of hospital stay but reduces the need for manipulation under anesthesia. (Harvey, 2010) The adjunctive home use of CPM may be an effective treatment option for patients at risk of knee flexion contractures, regardless of whether the patient is being treated as part of a worker's compensation claim or not. Recent literature suggests that routine home use of CPM has minimal benefit when combined with standard physical therapy, but studies conducted in a controlled hospital setting suggest that CPM can improve rehabilitation. (Dempsey, 2010) Criteria for the use of continuous passive motion devices: In the acute hospital setting, postoperative use may be considered medically necessary, for 4-10 consecutive days (no more than 21), for the following surgical procedures: (1) Total knee arthroplasty (revision and primary). (2) Anterior cruciate ligament reconstruction (if inpatient care). (3) Open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint (BlueCross BlueShield, 2005) For home use, up to 17 days after surgery while patients at risk of a stiff knee are immobile or unable to bear weight: (1) Under conditions of low postoperative mobility or inability to comply with rehabilitation exercises following a total knee arthroplasty or revision; this may include patients with: (a) complex regional pain syndrome; (b) extensive arthrofibrosis or tendon fibrosis; or (c) physical, mental, or behavioral inability to participate in active physical therapy. (2) Revision total knee arthroplasty (TKA) would be a better indication than primary TKA, but either OK if #1 applies.” Although the patient was diagnosed with post knee surgery, there is no justification for 30 days CPM. There is no documentation that the patient is at risk for stiff knee or any of the indications for CPM as per ODG guidelines. Therefore, the request for Continuous passive motion (CPM) rental for 30 days is not medically necessary.

Post-op knee brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, Knee brace is “Recommended as indicated below. Recommend valgus knee braces for knee OA. Knee braces that produce a valgus moment about the knee markedly reduce the net knee adduction moment and unload the medial compartment of the knee, but could be impractical for many patients. There are no high quality studies that support or refute the benefits of knee braces for patellar instability, ACL tear, or MCL instability, but in some patients a knee brace can increase confidence, which may indirectly help with the healing process. Criteria for the use of knee braces: Prefabricated knee braces may be appropriate in patients with one of the following conditions: 1. Knee instability. 2. Ligament insufficiency/deficiency. 3. Reconstructed ligament. 4. Articular defect repair. 5. Avascular necrosis. 6. Meniscal cartilage repair. 7. Painful failed total knee arthroplasty. 8. Painful high tibial osteotomy. 9. Painful unicompartmental osteoarthritis. 10. Tibial plateau fracture Custom-

fabricated knee braces may be appropriate for patients with the following conditions which may preclude the use of a prefabricated model: 1. Abnormal limb contour, such as: a. Valgus [knock-kneed] limb. b. Varus [bow-legged] limb. c. Tibial varum. d. Disproportionate thigh and calf (e.g., large thigh and small calf). e. Minimal muscle mass on which to suspend a brace. 2. Skin changes, such as: a. Excessive redundant soft skin. b. Thin skin with risk of breakdown (e.g., chronic steroid use). 3. Severe osteoarthritis (grade III or IV). 4. Maximal off-loading of painful or repaired knee compartment (example: heavy patient; significant pain). 5. Severe instability as noted on physical examination of knee. There is no clear and recent documentation of knee instability or ligament damage avascular necrosis following the right knee replacement.” Therefore, the request for post-op knee brace is not medically necessary.