

<b>Case Number:</b>	CM15-0089280		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	09/14/2012
<b>Decision Date:</b>	07/01/2015	<b>UR Denial Date:</b>	05/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2015

### 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: Illinois, California, Texas  
 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 is a 65-year-old female who sustained an industrial injury on 9/14/12. Injury occurred when she slipped and fell, sustaining a twisting type injury. Past medical history was positive for insulin-dependent diabetes. She underwent left knee arthroscopy with partial lateral meniscectomy and chondroplasty on 9/21/12. The 10/30/14 weight bearing x-rays demonstrated severe end-stage narrowing of the lateral joint compartment left knee, subchondral sclerosis, and lateral marginal osteophytes associated with marked valgus deformity 14 degrees compared to 6 degrees right. Lateral views showed evidence of slight posterior subluxation of the left femur consistent with chronic anterior cruciate ligament laxity, and advanced degenerative change in the lateral and patellofemoral joint compartments. Sunrise views demonstrated advanced patellofemoral degenerative change with relatively normal tracking at high flexion angles. The treating physician reports indicated the injured worker had on-going left knee pain with episodes of swelling and giving way. Conservative home management was noted. She was referred for consult regarding total knee arthroplasty due to worsening pain and functional loss. The 3/10/15 initial orthopedic report documented the history of injury and inability to regain normal range of motion or strength following the industrial injury. Current complaints included on-going lateral left knee pain with limited range of motion that was aggravated by weight bearing activity. She also had secondary persistent low back problems. Left knee exam documented antalgic gait, valgus alignment, 2+ effusion, vastus medialis oblique atrophy, pain with patellofemoral compression, lateral joint line tenderness with marked crepitus, popliteal fossa tenderness, 1+ Lachman's, range of motion -5 to 120 degrees, and hamstring contracture 10 degrees. Body mass

index was 23. The diagnosis included left knee osteoarthritis with marked valgus deformity, complete loss of lateral joint space, subchondral sclerosis, and marginal osteophytes, and advanced patellofemoral arthritis. The injured worker had used non-steroidal anti-inflammatory drugs (NSAIDs), and a cane. Corticosteroid injections were not recommended due to her diabetes. The treatment plan recommended total knee arthroplasty with pre-operative dental and cardiac clearance. The 4/24/15 treating physician response to a request for additional information stated that the injured worker reported extensive physiotherapy, corticosteroid injections, NSAIDs and activity modification. Functional limitations included limited standing, walking, kneeling, and stair climbing ability. The injured worker required a cardiology pre-operative evaluation based on positive family history for coronary artery disease and insulin dependent diabetes. The 5/4/15 utilization review non-certified the request for left total knee arthroplasty based on an absence of documentation that the patient had failed a reasonable attempt at adequate conservative treatment.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Left Total Knee Arthroplasty: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-344. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg (Acute & Chronic), Knee Joint Replacement, Knee Arthroscopy.

**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 40, and imaging findings of osteoarthritis. Guidelines recommend conservative treatment to include exercise therapy (supervised physical therapy and/or home exercise) and medications (NSAIDs or viscosupplementation injections or steroid injection). Guideline criteria have been met. This injured worker presents with on-going left knee pain with episodic swelling and giving way. Functional limitations have precluded return to work. Clinical exam findings are consistent with standing x-ray evidence of advanced osteoarthritis in the lateral and patellofemoral compartments. Body mass index is 23. There is evidence of reasonable operative and non-operative treatment, including prior physical therapy, NSAIDs, injections, activity modification, and cane. Therefore, this request is medically necessary.

#### **Associates Surgical Services: DME - Walker: 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), Knee & Leg (Acute & Chronic), Durable medical equipment (DME), Walking aids.

**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, Walking aids (canes, crutches, braces, orthoses, & walkers).

**Decision rationale:** The California MTUS guidelines do not provide specific guidelines for post-op ambulatory assistant devices. The Official Disability Guidelines state that disability, pain, and age-related impairments determine the need for a walking aid. Assistive devices can reduce pain and allow for functional mobility. The use of a walker is reasonable to allow for early post-op functional mobility following total knee arthroplasty. Therefore, this request is medically necessary.

**Pre operative Cardiology consult:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule, 1999 Edition, pages 92-93.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Females over the age of 65 with diabetes have known occult increased cardiovascular risk factor to support the medical necessity of a pre-operative cardiac clearance. Guideline criteria have been met based on patient's age, diabetes, the magnitude of surgical procedure, recumbent position, fluid exchange and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

**Pre operative Dental clearance:** 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) Infectious Diseases: Bone & joint infections: prosthetic joints and Other Medical Treatment Guidelines Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.; Institute for Clinical

Systems Improvement (ICSI). Perioperative protocol. Health care protocol. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Oct. 105 p.

**Decision rationale:** The California Medical Treatment Utilization Schedule and Official Disability Guidelines do not provide recommendations relative to dental clearance prior to joint surgeries. The Official Disability Guidelines do provide an overview of prosthetic joint infections indicating that infection is more likely to occur in revision arthroplasties than primary joint replacements. Other risk factors are identified and include obesity, neoplasm, diabetes, immunosuppression, corticosteroid use, rheumatoid arthritis, malignancy, prolonged surgery and perioperative infection away from the joint. The strongest risk factor is stated as wound infection in the postoperative period. The ODG further indicate that antibiotic prophylaxis is recommended for dental procedures for patients with artificial joints but the guidelines do not address pre-operative clearance relative to dental issues. The National Clearinghouse Guidelines provide perioperative protocol guidelines for dental patients with cardiac conditions at highest risk for adverse outcomes from infective endocarditis. There is rationale presented to support the medical necessity of a dental clearance for this injured worker. Although she is a diabetic, there is no evidence that she has a cardiac condition at this time. A cardiac clearance has been found medically necessary. It is reasonable to proceed with a dental clearance in order to decrease perioperative infection risk. Therefore, this request is medically necessary.