

Case Number:	CM13-0013679		
Date Assigned:	09/26/2013	Date of Injury:	02/09/2008
Decision Date:	01/23/2014	UR Denial Date:	07/17/2013
Priority:	Standard	Application Received:	08/19/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in Oklahoma and Texas. 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 physician 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:

The patient is a 52-year-old female who reported a work related injury on 02/09/2008 when she developed arthritic pains throughout her body. The patient has undergone physical therapy and total knee arthroplasty. The patient's medications include Vicodin, Norco, Celebrex, and Motrin. CT scan of the right knee dated 05/06/2013 revealed status post total knee arthroplasty with no evidence of periprosthetic fracture and osteopenia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Knee CPM RR x 6 weeks: Upheld

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 and Leg Chapter, Continuous passive motion.

Decision rationale: Recent clinical documentation submitted for review stated the patient complained of pain in her neck, shoulders, hips, ankles, and low back. The pain was noted to be radicular in nature and was rated as a 9/10. Physical exam of the right knee revealed increasing valgus of the right knee with 1+ tenderness to palpation along the parapatellar area. There was

lateral glide on the patella 40% from midline. Official Disability Guidelines indicate that continuous passive motion is recommended for in-hospital use or for home use in patients at risk for a stiff knee. Guidelines further state that routine home use of CPM has minimal benefit. Research suggests that CPM should be implemented in the first rehabilitation phase after surgery. Per clinical documentation submitted for review, the patient was noted to have total knee arthroplasty in 04/2012. There was no recent clinical documentation noting the rationale for the request for a knee CPM for the patient. As such, the decision for knee CPM RR x6 weeks is non-certified.

CPM Pad kit: Upheld

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 and Leg Chapter, Durable medical equipment.

Decision rationale: The recent clinical documentation submitted for review stated the patient had undergone a CT scan of the right knee on 05/06/2013 which had normal findings in terms of the alignment and rotation. No rotational abnormality was noted that would lead the knee to sublux laterally. It was felt that the patient's knee had healed in such a fashion that she had the patellofemoral mechanism, which was painful and a click with some obvious lateral subluxation. Official Disability Guidelines indicate that durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. There was a lack of documentation stating the medical need for a CPM machine for the patient or for a CPM pad kit. There was no rationale provided for this equipment for the patient in the submitted documentation. As such, the decision for CPM pad kit is non-certified.

Therma cooler system RR x 6 weeks: Upheld

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), Continuous-flow cryotherapy.

Decision rationale: Official Disability Guidelines indicate that continuous flow cryotherapy is recommended as an option after surgery, but is not for nonsurgical treatment. Postoperative use generally may be up to 7 days to include home use. Per clinical documentation submitted for review, the patient was noted to have total knee arthroplasty in 04/2012. There was no rationale given for the use of a Therma cooler system for the patient. Physical exam of the patient's right knee revealed a loss of ranges of motion. No laxity to varus/valgus and anterior or posterior stresses were noted. There was some evidence of mild crepitus. The treatment plan was noted to

request authorization for arthroscopic debridement and lysis of adhesions with possible lateral release of the knee. There was no recent clinical physical exam or documentation submitted for review giving a rationale for the Therma cooler system for the patient. As such, the request for Therma cooler system RR x6 weeks is non-certified.

Therma cooler pad/wrap: Upheld

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), Durable medical equipment.

Decision rationale: Official Disability Guidelines indicate that durable medical equipment is generally recommended if there is a medical need. Compression cryotherapy is recommended as an option after surgery but is not recommended for nonsurgical treatment. There was no rationale given for the use of the Therma cooler system for the patient. The Therma cooler system was not found to be medically necessary for the patient per the submitted clinical documentation. Therefore, the decision for Therma cooler pad/wrap is non-certified.