

<b>Case Number:</b>	CM13-0037959		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	03/16/2012
<b>Decision Date:</b>	03/05/2014	<b>UR Denial Date:</b>	10/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/24/2013

### 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 Orthopedic Surgery, has a subspecialty in Reconstructive Surgery, and is licensed to practice in Illinois 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 53-year-old who reported an injury on 03/16/2012 after a slip and fall caused a twisting motion to his left knee. The patient was treated conservatively with physical therapy and medications. The patient underwent an MRI that revealed an oblique tear of the medial meniscus. The patient's most recent clinical examination findings included mechanical symptoms of the left knee with medial joint line tenderness, a positive compression test, and a positive McMurray's test with 4/5 motor strength weakness. The patient's diagnoses included left knee medial meniscal tear, and right knee patellofemoral arthralgia. The patient's treatment plan included surgical intervention and continuation of a home exercise program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pre-operative medical clearance:** 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) Low Back Chapter, Pre-operative Testing

**Decision rationale:** The requested preoperative medical clearance is not medically necessary or appropriate. Official Disability Guidelines do not recommend preoperative testing for ambulatory surgeries. Clinical documentation submitted for review does provide evidence that the patient will undergo an ambulatory surgery. The clinical documentation submitted for review does not provide any evidence of a significant history to support the need for preoperative testing; therefore, preoperative medical clearance and would not be supported. The request for pre-operative medical clearance is not medically necessary or appropriate.

**Twelve post-operative physical therapy sessions to the left knee:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10 and 24.

**Decision rationale:** The requested 12 postoperative physical therapy sessions to the left knee are not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient is a surgical candidate for a meniscectomy. However, the California Medical Treatment Utilization Schedule recommends postoperative physical therapy be based on an initial course of treatment. The California Medical Treatment Utilization Schedule defines an initial course of treatment as half the number of the recommended visits. California Medical Treatment Utilization Schedule recommends 12 postoperative physical therapy visits for this type of surgery. Therefore, an initial course of treatment would be 6 postoperative therapy visits. The 12 postoperative physical therapy sessions exceeds this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. The request for twelve post-operative physical therapy sessions to the left knee is not medically necessary or appropriate.

**Fourteen days of home continuous passive motion device:** 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 and Leg (Acute and Chronic) Chapter.

**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 (CPM) Device Section.

**Decision rationale:** The requested continuous passive motion machine is not medically necessary or appropriate. Official Disability Guidelines do not recommend the routine use of a continuous passive motion machine. Official Disability Guidelines recommend the use of this type of machine after total knee arthroplasty or revision of a total knee arthroplasty. The clinical documentation submitted for review provides evidence that the patient is scheduled to undergo a meniscectomy. Therefore, the need for this equipment is not clearly established. There is no documentation that the patient will be at risk for immobility following surgery. The request for

fourteen days of home continuous passive motion device is not medically necessary or appropriate.

**Ninety days of stimulation unit for the left knee: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS (Transcutaneous Electrical Nerve Stimulation) Unit Section Page(s): 116.

**Decision rationale:** The requested 90 days of stimulation unit for the left knee is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend up to 30 days postoperative treatment with a TENS unit to control pain so that a patient can participate in an active therapy program. This request for 90 days is in excess of this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. The request for ninety days of stimulation unit for the left knee is not medically necessary or appropriate.

**Coolcare cold therapy: 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 and Leg (Acute and Chronic) Chapter.

**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 Surgery Chapter, Continuous Flow Cryotherapy Section.

**Decision rationale:** The requested Coolcare cold therapy unit is not medically necessary or appropriate. Official Disability Guidelines do recommend continuous flow cryotherapy for up to 7 days in the postsurgical management of a patient's pain. The request, as it is written, does not clearly identify whether this is for purchase or rental. Therefore, medical necessity cannot be established. The request for Coolcare cold therapy is not medically necessary or appropriate.