

<b>Case Number:</b>	CM13-0053868		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	04/09/2003
<b>Decision Date:</b>	03/26/2014	<b>UR Denial Date:</b>	11/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2013

### 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 and is licensed to practice in 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 63-year-old female who reported an injury on 05/09/2003 due to a slip and fall, reportedly causing injury to her ankles, back, knees, shoulder, low back and neck. The patient ultimately developed bilateral knee pain, with the right being greater than the left. The patient had complaints of instability. Physical findings included limited range of motion described as 0 to 120 degrees. The patient's treatment recommendations included a right total knee replacement followed by a left total knee replacement and postsurgical care to include a hinged brace, a continuous passive motion machine and Lidoderm patches.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**A continuous passive motion device (6 week rental): 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, Continuous Passive Motion.

**Decision rationale:** The requested continuous passive motion machine use for 6 weeks (post approved for the total knee arthroplasty) is not medically necessary or appropriate. The Official

Disability Guidelines recommend the use of a continuous passive motion unit for up to 21 days in the postsurgical management of a total knee replacement. The request exceeds this recommendation. There were no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested continuous passive motion unit for 6 weeks is not medically necessary or appropriate.

**A ThermoCooler system:** 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 ODG, Knee & Leg Chapter, Continuous Flow Cryotherapy

**Decision rationale:** The requested ThermoCooler system is not medically necessary or appropriate. The Official Disability Guidelines do recommend the use of a continuous flow cryotherapy unit for up to 7 days in the postsurgical management of a patient's pain. However, the request as it is written does not clearly identify an intended treatment duration or whether this durable medical equipment is for rental or purchase. Therefore, the medical necessity cannot be determined. As such, the requested ThermoCooler system is not medically necessary or appropriate.

**Skilled nursing evaluation and home blood draws for prothrombin time and INR levels:**  
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 Home Health Services Page(s): 51.

**Decision rationale:** The requested skilled nursing evaluation and home blood draws for prothrombin time and INR levels is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends home health services for patients who are homebound on a part-time or intermittent basis. The clinical documentation submitted for review does not provide any evidence that the patient cannot be evaluated on an outpatient basis by their physician. There is no documentation that the patient is considered homebound or will be homebound postsurgically. Therefore, the need for home health is not indicated. As such, the requested skilled nursing evaluation and home blood draws for prothrombin time and INR levels is not medically necessary or appropriate.

**The request for Lidoderm patches:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The requested Lidoderm patches were not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends Lidoderm patches for patients who have failed to respond to first-line therapies, to include antidepressants and anticonvulsants. The clinical documentation submitted for review does not provide any evidence that the patient's pain has failed to respond to first-line oral analgesics. Therefore, the use of topical lidocaine would not be indicated. As such, the requested Lidoderm patches are not medically necessary or appropriate.