

<b>Case Number:</b>	CM13-0059079		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	01/11/2005
<b>Decision Date:</b>	05/19/2014	<b>UR Denial Date:</b>	11/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/29/2013

### 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. The expert reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in California. 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/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 claimant is a 44-year-old female injured on 01/11/05. The clinical records provided for review include a prior Utilization Review of 11/25/13 certifying the need for a right knee arthroscopy with chondroplasty and debridement. There were recommendations for purchase of a cryotherapy device, 16 sessions of postoperative physical therapy, and a preoperative history and physical examination for "surgical clearance." Review of the claimant's medical records provided for review fails to identify any specific underlying comorbidity. No further clinical information is pertinent to the specific requests in this case.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**POST-OPERATIVE PHYSICAL THERAPY FOR THE RIGHT KNEE 2 TIMES PER WEEK FOR 8 WEEKS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** The MTUS Postsurgical Treatment Guidelines would not support the role of 16 sessions of postoperative therapy. The Postsurgical Guidelines following knee arthroscopy recommend up to 12 sessions over 12 weeks in the postoperative course. There is no documentation within the records provided for review to explain why this claimant would need

more than the recommended guidelines. The specific request for 16 sessions of initial therapy would thus exceed the Postsurgical Guidelines and cannot be recommended as medically necessary and appropriate.

**COLD THERAPY UNIT (RENTAL OR PURCHASE):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: Knee Procedure- section on Continuous-flow cryotherapy

**Decision rationale:** The Official Disability Guidelines recommend the use of a cold therapy unit for up to seven days post surgery including home use. The request in this case does not specify the length of time for rental of the cold therapy unit. This information would be necessary before the rental of the unit can be recommended as medically necessary. The request is therefore not medically necessary and appropriate.

**PREOPERATIVE HISTORY AND PHYSICAL EXAMINATION FOR SURGICAL CLEARANCE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, 2nd Edition, (2004) section on Independent Medical Examinations and Consultations, page 127.

**Decision rationale:** The Official Disability Guidelines recommend the use of a cold therapy unit for up to seven days post surgery including home use. The request in this case does not specify the length of time for rental of the cold therapy unit. This information would be necessary before the rental of the unit can be recommended as medically necessary. The request is therefore not medically necessary and appropriate.