

Case Number:	CM13-0062034		
Date Assigned:	12/30/2013	Date of Injury:	07/22/2009
Decision Date:	06/23/2014	UR Denial Date:	11/07/2013
Priority:	Standard	Application Received:	12/05/2013

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 Arizona. 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 injured worker is a 46-year-old male who reported an injury on 07/22/2009. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to his left knee and ultimately underwent left knee arthroscopy in 08/2010. The injured worker's treatment history included medications, activity modifications, physical therapy, knee brace, and knee injections. The injured worker was evaluated on 10/04/2013. It was documented that the injured worker had failed conservative management and had undergone x-rays indicating a severe arthrosis and bone on bone osteoarthritis of the patellofemoral joint. The injured worker's left knee physical findings included diffuse tenderness of the joint with quadriceps atrophy, medial and lateral joint line tenderness, patellofemoral facet tenderness, and range of motion described as 0 to 120 degrees in flexion. It was noted that the injured worker's diagnoses included left knee degenerative joint disease; status post left knee arthroscopy, contracture of the left small finger, left hip greater trochanter bursitis, herniated disc of the lumbar spine, lumbar radiculopathy, and headaches. The injured worker's treatment plan included a left total knee replacement with postoperative care to include a continuous passive motion machine, a [REDACTED] machine, and postoperative physical therapy. The injured worker was again evaluated on 02/28/2014. It was noted that the injured worker was scheduled for surgical intervention on 03/13/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

18 SESSIONS OF POST-OPERATIVE PHYSICAL THERAPY FOR THE LEFT KNEE, THREE (3) TIMES PER WEEK FOR SIX (6) WEEKS,: Upheld

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

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

Decision rationale: The requested 18 sessions of postoperative physical therapy for the left knee 3 times per week for 6 weeks is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends up to 24 postoperative physical therapy visits following total knee replacement. However, California Medical Treatment Utilization Schedule recommends an initial course of treatment equal to half the number of recommended visits to establish efficacy. The clinical documentation submitted for review does indicate that the injured worker is scheduled for surgical intervention in 03/2014. However, the request exceeds the recommended 12 visit initial course of treatment. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested 18 sessions of postoperative physical therapy for the left knee 3 times per week for 6 weeks is not medically necessary or appropriate.

CONTINUOUS PASSIVE MOTION (CPM) MACHINE FOR THE KNEE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Continuous Passive Motion (CPM).

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)

Decision rationale: The requested continuous passive motion machine for the knee is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker is scheduled for a total knee replacement in 03/2014. California Medical Treatment Utilization Schedule does not address the use of continuous passive motion machines. Official Disability Guidelines recommend up to 21 days of usage of a continuous passive motion machine following a total knee replacement. However, the request as it is submitted does not clearly identify a duration of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested continuous passive motion machine for the knee is not medically necessary or appropriate.

35-DAY RENTAL OF A [REDACTED] WITH DVT COLD COMPRESSION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee Chapter, Continuous-Flow Cryotherapy.

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 FLOW CRYOTHERAPY

Decision rationale: The requested 35 day rental of a [REDACTED] with DVT cold compression is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address continuous flow cyrotherapy. Official Disability Guidelines recommend up to 7 days of the use of a continuous flow cyrotherapy compression unit in the management of postsurgical total knee replacement pain. The request exceeds this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested 35 day rental of a [REDACTED] with DVT cold compression is not medically necessary or appropriate.