MAXIMUS Federal Services

Case Number:	CM13-0068379		
Date Assigned:	01/03/2014	Date of Injury:	11/16/2010
Decision Date:	05/29/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/19/2013

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 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 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 62-year-old who reported an injury on November 16, 2010. The mechanism of injury was not stated. Current diagnoses include right shoulder impingement, cervical sprain, lumbar sprain, right knee medial meniscus tear, bilateral referred hip pain, anxiety/depression, insomnia, and morbid obesity. The injured worker was evaluated on July 15, 2013. The injured worker reported persistent pain in the neck, right shoulder, low back, and hip. Previous conservative treatment was not mentioned. Physical examination revealed a slightly antalgic gait, medial joint line tenderness, and positive McMurray's testing. Treatment recommendations included a right knee arthroscopy. It is noted that the injured worker underwent right knee arthroscopic subtotal medial meniscectomy and partial lateral meniscectomy with synovectomy and placement of a pain pump on September 27, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Q-TECH DVT (DEEP VEIN THROMBOSIS) PREVENTION SYSTEM, PROVIDED ON SEPTEMBER 27, 2013: 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 & Leg (Acute & 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 & Leg Chapter, Venous Thrombosis.

Decision rationale: Official Disability Guidelines recommend identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures such as consideration for anticoagulation therapy. Aspirin may be the most effective choice to prevent pulmonary embolism and venous thromboembolism in patients undergoing orthopedic surgery. As per the documentation submitted, the injured worker underwent a right knee arthroscopic surgery on 09/27/2013. However, there is no indication that this injured worker is at high risk for developing a postoperative venous thrombosis. There is no mention of a contraindication to oral anticoagulation therapy as opposed to a motorized unit. The request for Q-Tech DVT prevention system, provided on september 27, 2013 is not medically necessary or appropriate.

30-DAY RENTAL OF A KNEE CPM PADS: 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 and Leg Chapter, 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 & Leg Chapter, Continuous Passive Motion.

Decision rationale: The Official Disability Guidelines state continuous passive motion is recommended for four to ten consecutive days in the acute hospital setting and for up to seventeen days after surgery. The current request for a 30 day rental exceeds guideline recommendations. The request for a thirty day rental of knee CPM pads is not medically necessary or appropriate.

Q-TECH COLD THERAPY RECOVERY SYSTEM: 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 & Leg Chapter, Continuous-Flow Cryotherapy Section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Continuous Flow Cryotherapy.

Decision rationale: The Official Disability Guidelines state continuous flow cryotherapy is recommended as an option after surgery. Postoperative use generally may be up to seven days, including home use. While the injured worker may meet criteria for a seven day use of a Q-Tech cold therapy recovery system, the current request does not specify the total duration of treatment. The request for a Q-Tech cold therapy recovery system is not medically necessary or appropriate.

OPTIMUM HOME REHAB KIT: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Home Exercise Kit.

Decision rationale: The Official Disability Guidelines state home exercise kits are recommended where home exercise programs are also recommended. There is no sufficient evidence to support the recommendation of any particular exercise regimen over another. While the injured worker is noted to be status post right knee arthroscopic surgery on September 27, 2013, guidelines do not recommend a specific exercise kit over traditional exercise regimens. The medical necessity has not been established. The request for an optimum home rehab kit is not medically necessary or appropriate.

PROGRAMMABLE PAIN PUMP: 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 and Leg Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Postoperative Pain Pump.

Decision rationale: The Official Disability Guidelines state postoperative pain pumps are not recommended. Recent quality studies do not support the use of pain pumps. There is no mention of a contraindication to oral pain management as opposed to a programmable pump. The medical necessity has not been established. The request for a programmable pain pump is not medically necessary or appropriate.