

Case Number:	CM14-0012738		
Date Assigned:	02/21/2014	Date of Injury:	05/04/2009
Decision Date:	06/30/2014	UR Denial Date:	01/14/2014
Priority:	Standard	Application Received:	01/31/2014

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 Physical Medicine & Rehabilitation 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 injured worker is a 71-year-old female who reported an injury on 05/04/2009. On 03/03/2014 the injured worker attended a preoperative visit due to a surgery scheduled for 03/12/2014 for the injured worker's right knee. The injured worker stated that while working as a cafeteria worker, she gradually developed pain in her bilateral knees. She attributed the pain to prolonged standing, excessive walking, and carrying heavy objects while working. The injured worker stated that she had been given 3 injections of Synvisc into her right knee. She reported temporary improvement of her symptoms following the injections. A right total knee replacement was recommended and was approved. As of the 03/12/2014 visit, the injured worker reported no pain in her right knee at rest; however, she developed stiffness and pain in her right knee with prolonged standing and when she stood up after prolonged sitting. She rated her pain to the right knee at a 6/10. Upon evaluation of the right knee, there was diffuse tenderness, maximal over the patellar tendon. The treatment plan included clearance from a cardiologist due to the injured worker's history of coronary artery disease with a 3 vessel bypass and risk factors of hypertension, diabetes, and hyperlipidemia. The documents submitted for review did not include a request for authorization of medical treatment. The documentation indicated a total right knee replacement, thus providing rationale for both of the requests for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

POST-OPERATIVE STAY IN REHAB CENTER (NO DAYS SPECIFIED): 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 Knee, Skilled nursing facility care.

Decision rationale: The request for POST-OPERATIVE STAY IN REHAB CENTER (NO DAYS SPECIFIED) is non-certified. The Official Disability Guidelines indicate that skilled nursing facility is recommended up to 10 through 18 days or 6 to 12 days as inpatient rehabilitation facility is an option but not a requirement, depending on the degree of functional limitation, ongoing skilled nursing and/or rehabilitation care needs, patient ability to participate with rehabilitation, documentation of continued progress with rehabilitation goals, and availability of proven facilities, immediately following 3 to 4 days acute hospital stay for arthroplasty. The Guidelines also indicate that for patients with knee replacement, those in inpatient rehabilitation facilities had better outcomes than did skilled nursing facilities because earlier and more intensive rehabilitation was associated with better outcomes. Although the Official Disability Guidelines do indicate 6 to 12 days in an inpatient rehabilitation facility is an option, it is also indicates it is not a requirement but necessity is determined depending on the degree of functional limitation. The documents provided do not adequately support current functional deficit prior to surgery or the anticipated need for a post-operative rehab stay. Due to a lack of documentation to support the need for inpatient rehabilitation and due to lack of days requested in the request, the decision for POST-OPERATIVE STAY IN REHAB CENTER (NO DAYS SPECIFIED) is non-certified.

POST-OPERATIVE THERMACOOLER SYSTEM X 2 WEEKS FOR RIGHT KNEE:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, 2ND. EDITION, 2004., CHAPTER 13 (KNEE COMPLAINTS), 38

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG) Knee, Continuous-flow Cryotherapy.

Decision rationale: The request for post-operative thermacooler system x 2 weeks for right knee is non-certified. The Official Disability Guidelines indicate that continuous flow cryotherapy is recommended as an option after surgery. The Guidelines indicate postoperative use is generally up to 7 days including home use. The request for post-operative thermacooler system x 2 weeks for right knee would exceed the guideline recommendation of 7 days postoperatively. Therefore, the request for POST-OPERATIVE THERMACOOLER SYSTEM X 2 WEEKS FOR RIGHT KNEE is non-certified.