

Case Number:	CM14-0014361		
Date Assigned:	02/26/2014	Date of Injury:	08/25/2010
Decision Date:	11/28/2014	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	02/04/2014

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 Family Medicine and is licensed to practice in New Jersey and New York. 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 64 year-old male who was injured on 8/25/10. The patient was leaning over to pull on a cord and felt a burning sensation in his right shoulder with loss of function and range of motion. He was diagnosed with a rotator cuff tear which could not be repaired due to hypoxia during intubation. The patient then began with left shoulder pain due to compensation. The patient had a right shoulder reverse arthroplasty on 9/10/13. He improved with physical therapy afterwards. His medications included narcotics, Elavil, Ambien, Tizanidine, and Lyrica. The patient complains of right knee pain which is compensatory after a left total knee replacement for an injury that occurred two years prior. He was diagnosed with lumbago and right knee pain and osteoarthritis. The patient had said analgesics and anti-inflammatories did not improve symptoms. The patient did not want to try cortisone or viscoelastic injections and requested a right total knee replacement. The current request is for continuous passive motion machine, cold therapy ice unit, Xarelto for post-operative anti-coagulation, crutches, and walker. It should be noted that the majority of the chart focused on the patient's shoulder pain, repair, and post-operative therapy. There was not much documentation on the knee injury, pain, and specific therapies used. It is also not clear if a total knee replacement was authorized.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continuous passive motion machine (CPM): 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 and Leg Chapter, Continuous Passive Motion Devices

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 Devices.

Decision rationale: Continuous passive motion device is not medically necessary at this time. Because MTUS does not cover these guidelines, ODG was referenced. Although it is indicated for a total knee arthroplasty, there isn't clear indication that the patient is going to have a total knee replacement (TKR). The majority of the chart was spent describing the patient's shoulder pain and course of treatment. There were two notes that mention his knee pain, one of which described how he had used analgesics and anti-inflammatories without relief and wanted to proceed directly to a TKR. There was no documentation of any physical therapy for his knee. An authorization for a total knee replacement was being requested but is not clear at this time if it was granted. Therefore, at this point, the request is considered not medically necessary.

Cold therapy ice unit: 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) Treatment Index, second edition (web), 2013, Knee and Leg 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, Continuous-Flow Cryotherapy.

Decision rationale: The request is considered not medically necessary at this time. Cold therapy ice unit or continuous-flow cryotherapy is not addressed by the MTUS, therefore ODG guidelines were used. It is recommended as an option after surgery, but not for nonsurgical treatment. Although it is justified in postoperative management of knee surgery, there isn't clear indication that the patient is going to have a TKR. The majority of the chart was spent describing the patient's shoulder pain and course of treatment. There were two notes that mention his knee pain, one of which described how he had used analgesics and anti-inflammatories without relief and wanted to proceed directly to a TKR. There was no documentation of any physical therapy for his knee. Authorization for a TKR was being requested but is not clear at this time if it was granted. Therefore, at this point, the request is considered not medically necessary.

Xarelto 10 mg, 12 tablets for post-operative anticoagulation: 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)

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, Rivaroxaben

Decision rationale: The request is not medically necessary. Xarelto was not addressed in MTUS but in ODG guidelines. Although Xarelto is recommended for DVT and PE prophylaxis in knee and hip surgery, there isn't clear indication that the patient is going to have a TKR. The majority of the chart was spent describing the patient's shoulder pain and course of treatment. There were two notes that mention his knee pain, one of which described how he had used analgesics and anti-inflammatories without relief and wanted to proceed directly to a TKR. There was no documentation of any physical therapy for his knee. Authorization for a TKR was being requested but is not clear at this time if it was granted. Therefore, at this point, the request is considered not medically necessary.

Crutches, walker: 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 and Leg, Walking Aids.

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, Walking Aids

Decision rationale: The request for walker and crutches is not medically necessary. ODG guidelines were used since MTUS does not address durable medical equipment. There isn't clear indication that the patient is going to have a TKR, therefore postoperative durable medical equipment is not needed at this time. The majority of the chart was spent describing the patient's shoulder pain and course of treatment. There were two notes that mention his knee pain, one of which described how he had used analgesics and anti-inflammatories without relief and wanted to proceed directly to a TKR. There was no documentation of any physical therapy for his knee. Authorization for a TKR was being requested but is not clear at this time if it was granted. Therefore, at this point, the request is considered not medically necessary.