

Case Number:	CM14-0122556		
Date Assigned:	08/06/2014	Date of Injury:	04/11/2008
Decision Date:	09/12/2014	UR Denial Date:	07/29/2014
Priority:	Standard	Application Received:	08/04/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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:

This case involves a male who sustained an injury on April 11, 2008. The utilization review determination dated July 29, 2014, recommends non-certification of a cold therapy machine x 14 days with modification to x 7 days, postoperative follow-ups x 5 with modification to x 1, and physical therapy 2x6weeks modified to physical therapy 2x6 weeks. A progress note dated May 28, 2014, identifies subjective complaints of unresolved left knee pain and disability, unresponsive to prior steroid injections, anti-inflammatories, Supartz, arthroscopic debridement of the knee, shoe inserts, and knee supports. The patient has unresolved pain and disability which impairs his quality of life significantly. Physical examination identifies a varus deformity of about 7 to 8, crepitation, warmth, swelling of the medial compartment, and a positive effusion. The diagnosis is advanced osteoarthritis of the left knee. The treatment plan recommends a request for authorization for a left knee hemi-arthroplasty, a preoperative history and physical, 2 to 3 days of hospitalization, and 12 postoperative physical therapy visits. An operative report dated July 21, 2014 indicates a right partial knee replacement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy Machine x 7 days: Overturned

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 Official Disability Guidelines (ODG), Knee Chapter, Continuous-flow cryotherapy.

Decision rationale: Regarding the request for cold therapy machine x 7 days, California MTUS does not address the issue. Official Disability Guidelines (ODG) supports the use of continuous-flow cryotherapy for up to 7 days after knee surgery. Within the documentation available for review, the patient underwent a right partial knee replacement and the requested cold therapy machine was appropriately modified in utilization review for up to 7 days of use. As such, the currently requested cold therapy machine x 7 days is medically necessary.

Postoperative Follow up x 1: Overturned

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 Official Disability Guidelines (ODG), Chronic Pain Chapter, Office visit.

Decision rationale: Regarding the request for post-operative follow-up x1, Official Disability Guidelines (ODG) state that office visits are recommended as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. Within the documentation available for review, the patient is status post a right partial knee replacement. As such, the currently requested one post-operative follow-up x 1 is medically necessary.

Physical Therapy 2 x 6 week: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Physical Therapy.

Decision rationale: Regarding the request for physical therapy 2x6 weeks, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. Official Disability Guidelines (ODG) has more specific criteria for the ongoing use of physical therapy and recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, the patient is status post a right partial knee replacement. The guidelines recommend

an initial trial of 12 visits. As such, the current request for physical therapy 2x6 weeks is medically necessary.