

Case Number:	CM14-0131654		
Date Assigned:	09/26/2014	Date of Injury:	07/27/1993
Decision Date:	10/31/2014	UR Denial Date:	08/07/2014
Priority:	Standard	Application Received:	08/18/2014

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 Orthopedic Surgery 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:

57-year-old male with reported industrial injury of 7/27/1993. Exam note 11/8/2013 demonstrates continued knee pain without significant changes. There is associated swelling and interference of sleep. The patient denies clicking, popping, grinding or locking or buckling of the knee. Examination discloses an antalgic gait with the left knee trace effusion. There is tenderness over the medial joint line bilaterally with intermittent clicking of the left knee with passive range of motion and crepitus of the knee. A positive McMurray's is noted. Active range of motion of the left knee is from -5 extension 230 of flexion. MRI of the left knee performed on 10/30/2013 demonstrates a horizontal cleavage tear of the anterior horn, body and posterior horn medial meniscus. There are osteoarthritic changes of all 3 compartments most notably the medial compartment with degenerative changes of the anterior cruciate ligament. Recommendations include left knee arthroscopy with repair of internal derangement, partial medial meniscectomy, debridement and chondroplasty.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home health care three (3) times per week for (2) weeks, for lab draws for prothrombin time (PT) and international normalized ratio (INR): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Preoperative testing

Decision rationale: CA MTUS/ACOEM is silent on the issue of preoperative clearance and testing. ODG, Knee and Leg is silent on the issue of preoperative testing therefore alternative guidelines were utilized. ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. In this case the patient is a healthy 57 years old without history of coagulation abnormalities concerning to warrant PT and INR blood draws. Therefore, the Home health care three (3) times per week for (2) weeks, for lab draws for prothrombin time (PT) and international normalized ratio (INR) is not medically necessary and appropriate.

Postoperative purchase of an Iceman and pad: 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, 12th Edition (web), 2014, 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: CA MTUS/ACOEM is silent on the issue of cryotherapy. According to ODG, Knee and Leg Chapter regarding continuous flow cryotherapy it is a recommended option after surgery but not for nonsurgical treatment. It is recommended for upwards of 7 days postoperatively. In this case the request has an unspecified amount of days. Therefore the Postoperative purchase of an Iceman and pad is not medically necessary and appropriate.

Postoperative home physical therapy three (3) times per week for two (2) weeks in treatment of the right knee: Overturned

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

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

Decision rationale: According to the CA MTUS/Post-Surgical Treatment Guidelines, Knee Meniscectomy, page 24, 12 visits of therapy are recommended after arthroscopy with partial meniscectomy over a 12-week period. Initially of the recommended visits are authorized. As the request is for 6 postoperative therapy visits, the guidelines have been met and therefore the request of Postoperative home physical therapy three (3) times per week for two (2) weeks in treatment of the right knee is medically necessary and appropriate.