MAXIMUS Federal Services

Case Number:	CM14-0132172		
Date Assigned:	08/22/2014	Date of Injury:	05/23/2014
Decision Date:	10/02/2014	UR Denial Date:	08/04/2014
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 Emergency Medicine 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 46 year old male who reported an injury on 05/23/2014. The mechanism of injury occurred when the injured worker was struck on the side of his leg by a metal bar. His diagnoses included an anterior cruciate ligament tear. His past treatments included surgery, a home exercise program, aspiration of the fluid in the knee, medications, and a knee brace. The injured worker's diagnostic exams included an MRI and X-ray of the left knee. His surgical history included a left knee arthroscopy and anterior cruciate ligament reconstruction on 08/12/2014. On 06/04/2014 the injured worker reported left knee pain, swelling, and loss of motion. Examination of the left knee noted moderate effusion, mild instability to valgus stress, and mild tenderness in the lateral compartment. The most recent progress report on 08/04/2014 was handwritten and difficult to decipher. The only medication indicated in the clinical notes was non-steroidal anti-inflammatory treatment. The treatment plan included the use of 1 cold therapy unit for 4 weeks and the use of a continuous passive motion machine for 4 weeks post left knee arthroscopy. The rationale for the request was not indicated in the clinical notes. The Request for Authorization form was signed and submitted on 07/23/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Cold Therapy Unit (4 week rental) between 7/23/2014 and 9/26/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines)Knee & Leg (Acute & Chronic)

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 for 1 Cold therapy unit for 4 weeks between 07/23/2014 and 09/26/2014 is not medically necessary. The Official Disability Guidelines recommended the use of a continuous-flow unit as an option after surgery, but not for nonsurgical treatment. The postoperative time frame may be up to 7 days. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. Based on the clinical notes, the injured worker had a left knee arthroscopy on 08/12/2014. The guidelines recommend the use of cold therapy up to 7 days post-operatively after knee arthroscopy. The request for 1 cold therapy unit for 4 weeks exceeds the recommended time frame for use. The use of a cold therapy unit after 7 days shows no significant increase in functionality or pain improvement and is therefore not supported. As such, due to the excessive request of 1 cold therapy unit for 4 weeks, the request for a cold therapy unit is not supported and thus not medically necessary.

1 Continuous Passive Motion machine (4 week rental) between 7/23/2014 and 9/26/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines)Knee & Leg (Acute & Chronic)

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 passive motion (CPM).

Decision rationale: The request for 1 continuous passive motion machine for 4 weeks between 07/24/2014 and 09/26/2014 is not medically necessary. The Official Disability Guidelines recommend the use of a continuous passive motion machine for in-hospital use or for home use in patients at risk of a stiff knee, immobilization and an inability to bear weight. In the hospital following an inpatient anterior cruciate ligament reconstruction, the guidelines support use of continuous passive motion for 4-10 days. For injured workers who are at risk of a stiff knee, immobile, or unable to bear weight, the guidelines support in home use for up to 17 days after surgery. The beneficial effects over regular physical therapy may be small and routine home use of a continuous passive motion machine has minimal benefit. Based on recent study results, routine use of prolonged continuous passive motion therapy should be reconsidered, since neither long-term effects nor better functional performance were detected. Based on the clinical notes the injured worker had a left knee arthroscopy on 08/12/2014. Subsequently, the Official Disability guidelines do not support the use of a continuous passive motion machine longer than 17 days in a home setting. Therefore, due to the lack of evidence based studies supporting

increased functional performance after routine continuous passive motion machine use, the request is not medically necessary.