

<b>Case Number:</b>	CM14-0029429		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	08/31/2010
<b>Decision Date:</b>	08/04/2014	<b>UR Denial Date:</b>	02/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/07/2014

### 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 Surgeon, 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 64-year-old male with an injury reported on 08/31/2010. The mechanism of injury was noted as a fall. The clinical note dated 02/04/2014 reported that the injured worker complained of low back and bilateral knee pain. The physical examination of the injured worker's lumbar spine revealed tenderness to the paraspinal area with guarding and the lumbar spine had a decreased range of motion secondary to pain. The examination of the injured worker's left knee revealed tenderness to palpation, positive crepitus, and 4/5 motor strength. The injured worker's left knee range of motion demonstrated flexion to 119 degrees and extension to 0 degrees. The injured worker's diagnoses included chondral right knee; right knee sprain; lumbar spine sprain/strain with left lower extremity radicular pain; left knee sprain; and left knee patellofemoral arthroplasty. The MRI dated 08/23/2013 to the left knee revealed a medial meniscus tear. The injured worker is pending a surgical procedure for a left partial medial meniscectomy, chondroplasty, and debridement per [REDACTED]. The Physician requested postoperative physical therapy, continous home CPM(Continuous Passive Motion), a Surg-Stim unit, and a cold care therapy unit for postoperative recovery. The Request for Authorization was submitted on 03/07/2014. The injured worker's prior treatments were not provided within the clinical notes

### IMR ISSUES, DECISIONS AND RATIONALES

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

**supervised post-operative rehabilitative therapy twelve (12) sessions (3 x 4) have been modified to six (6) post-operative physical therapy sessions: Upheld**

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

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

**Decision rationale:** The CA MTUS guidelines state controversy exists about the effectiveness of therapy after arthroscopic partialmeniscectomy. Functional exercises after hospital discharge for total knee arthroplasty result in a small to moderate short-term, but not long-term, benefit. In the short term therapy interventions with exercises based on functional activities may be more effective after total knee arthroplasty than traditional exercise programs, which concentrate on isometric muscle exercises and exercises to increase range of motion in the joint. Within the physician documentation, an adequate and complete postoperative assessment of the injured worker's functional condition is not provided. There is a lack of documentation indicating the injured worker has significant postoperative functional deficits. Moreover, it cannot be determined if the requesting provider is requesting 12 sessions or 6 sessions of postoperative physical therapy. Given the information provided, there is insufficient evidence to determine the appropriateness of postoperative physical therapy to warrant the medical necessity. Therefore, the request is not medically necessary.

**home continuous passive motion (CPM) device:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, for knee and leg regarding Continuous passive motion (CPM).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee, Continuous passive motion (CPM).

**Decision rationale:** The Official Disability Guidelines recommend Continuous Passive Motion (CPM) for home use, up to 17 days after surgery while patients at risk of a stiff knee are immobile or unable to bear weight: Under conditions of low postoperative mobility or inability to comply with rehabilitation exercises following a total knee arthroplasty or revision; this may include patients with: complex regional pain syndrome; extensive arthrofibrosis or tendon fibrosis; or physical, mental, or behavioral inability to participate in active physical therapy. Revision total knee arthroplasty (TKA) would be a better indication than primary TKA. There is a lack of clinical information indicating the injured worker is at risk of a stiff knee of immobility due to the recent surgical procedure and/or weight-bearing status. Moreover, the requesting provider did not specify the duration of use of the CPM machine. Given the information provided, there is insufficient evidence to determine the appropriateness of a CPM machine to warrant the medical necessity. Thus, the request for Home Continuous Passive Motion (CPM) Device is not medically necessary.

**Surg-Stim unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116.

**Decision rationale:** The request for a surg-stim unit is non-certified. The injured worker complained of low back and bilateral knee pain. The treating physician's rationale for the surg-stim unit is for the injured worker's recovery. The California MTUS guidelines for the use of TENS unit requires chronic intractable pain documentation of at least a three month duration. There needs to be evidence that other appropriate pain modalities have been tried (including medication) and failed. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. Other ongoing pain treatment should also be documented during the trial period including medication usage. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. There is a lack of clinical documentation that the injured worker has had chronic intractable pain for at least 3 months' duration. There is a lack of clinical information indicating the injured worker's pain was unresolved with conservative care to include physical therapy, home exercises, and/or oral medication therapy. Furthermore, the requesting provider did not specify the utilization frequency, duration, or the location of the application of the surg-stim unit being requested. As such, the request for Surg-Stim Unit is not medically necessary.

**Coolcare cold therapy has been modified to seven (7) day rental of a cold therapy unit:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee and leg chapter, continuous-flow cryotherapy section.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee, Cold/heat packs.

**Decision rationale:** The CA MTUS/ACOEM guidelines recognize an at-home local applications of cold in first few days of acute complaint; thereafter, applications of heat or cold. The Official Disability Guidelines recommend ice massage compared to control had a statistically beneficial effect on ROM, function and knee strength. Cold packs decreased swelling. Hot packs had no beneficial effect on edema compared with placebo or cold application. Ice packs did not affect pain significantly compared to control in patients with knee osteoarthritis. There is a lack of clinical information indicating the injured worker requires cold therapy to his knee. There is a lack of documentation indicating the injured worker has significant functional deficits requiring coolcare cold therapy. Given the information provided, there is insufficient evidence to determine the appropriateness of coolcare cold therapy to

warrant the medical necessity. Therefore, the request for Coolcare Cold Therapy has Been Modified to Seven (7) day Rental of a Cold Therapy Unit is not medically necessary.