

Case Number:	CM14-0036395		
Date Assigned:	06/25/2014	Date of Injury:	12/03/2012
Decision Date:	07/25/2014	UR Denial Date:	03/12/2014
Priority:	Standard	Application Received:	03/25/2014

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 & Rehabilitation has a subspecialty in Pain Medicine 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:

The injured worker is a 47-year-old male who reported an injury on 12/03/2012 with the mechanism of injury not cited within the documentation provided. In the clinical notes dated 06/16/2014, it was annotated that the injured worker was status post left knee scope dated 03/12/2014. It was also noted that the injured worker had improved pain, which he rated 2/4/10. It was also noted that the injured worker had completed 6 of 12 physical therapy visits. The diagnoses included status post left knee scope medial meniscectomy and right hip sprain/strain. The treatment plan included for the injured worker to complete the remaining 6 postoperative sessions of therapy to the left knee, continuation of home exercise, use of bracing, and follow-up in 4 to 6 weeks. A request for authorization for CPM, cold therapy, SurgiStim 4, postop knee brace and crutches was submitted on 08/05/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Postoperative Continuous Passive Motion (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, Knee and Leg, 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 (ODG) state that continuous passive motion (CPM) is recommended for in hospital use or for home use in injured workers at risk of a stiff knee based on demonstrated compliance and measured improvements, but the beneficial effects over regular physical therapy may be small. Routine home use of CPM has minimal benefit. The criteria for the use of a CPM for acute hospital setting are a total knee arthroplasty, anterior cruciate ligament reconstruction, and open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint. The use of the CPM may be considered medically necessary postoperative for 4 to 10 consecutive days (no more than 21). In the clinical notes provided for review, it is indicated that the injured worker is 3 months status postoperative medial meniscectomy. The clinical notes also lack the indication and rationale for the use of postoperative continuous passive motion. There is also lack of documentation of the area of application, frequency, and duration to which the CPM is to be used. Therefore, the request for postoperative continuous passive motion (CPM) is not medically necessary.

Postoperative Knee Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg, Knee Brace.

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

Decision rationale: The Official Disability Guidelines (ODG) state that a knee brace is recommended for knee instability; ligament insufficiency/deficiency; reconstructed ligament; articular defect repair; avascular necrosis; meniscal cartilage repair; painful total knee arthroplasty; painful high tibial osteotomy; painful knee compartmental osteoarthritis and tibial plateau fracture. The guidelines also state that there are no high quality studies that support or refute the benefits of knee braces for patellar instability, ACL tear, or MCL instability, but in some injured workers a knee brace can increase confidence which may indirectly help with the healing process. In all cases, braces need to be used in conjunction with a rehabilitation program and are necessary only if the injured worker is going to be stressing the knee under load. In the clinical notes provided for review, it is indicated that the injured worker had improved function and is participating in physical therapy. There is also lack of documentation of knee instability within the physical examination to warrant the use of a knee brace. Therefore, the request for postoperative knee brace is not medically necessary.

Postoperative Cold Therapy 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, Knee and Leg, 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, Continuous-flow cryotherapy.

Decision rationale: The Official Disability Guidelines (ODG) state that continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use may be up to 7 days including home use. In the postoperative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. In the clinical notes provided for review, it is annotated that the injured worker is status post left knee scope medial meniscectomy dated 03/12/2014. It is also annotated that the injured worker has improvement to his left knee with physical therapy. There is also a lack of documentation of the physician requesting the use of postoperative cold therapy unit within this clinical note. Therefore, the request for postoperative cold therapy unit is not medically necessary.

Postoperative Surgistim 4: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines page(s) TEN, post operative pain (transcutaneous electrical nerve stimulation) Page(s): 116-117.

Decision rationale: The California MTUS Guidelines state that a TENS for postoperative pain is recommended as a treatment option for acute postoperative pain in the first 30 days postsurgery. Transcutaneous electric nerve stimulation (TENS) appears to be most effective for mild to moderate for thoracotomy pain. It has been shown to be of lesser effect or not at all for other orthopedic surgical procedures. The proposed necessity of the unit should be documented upon request. Rental would be preferred over purchase during this 30 day period. In the clinical notes provided for review, it is annotated that the injured worker has shown improvement with physical therapy. The request for a SurgiStim 4 is not addressed within this clinical note. Furthermore, it is annotated that the injured worker is status post left knee medial meniscectomy dated 03/12/2014, which exceeds the postoperative phase of 30 days. Therefore, the request for postoperative SurgiStim 4 is not medically necessary.