

Case Number:	CM14-0042103		
Date Assigned:	06/30/2014	Date of Injury:	05/10/2013
Decision Date:	08/25/2014	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	04/08/2014

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 and is licensed to practice in Nevada. 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 51-year-old male who was reportedly injured on May 10, 2013. The mechanism of injury was not listed in these records reviewed. The most recent progress note dated February 24, 2014, indicated that there were ongoing complaints of bilateral shoulder and right knee pains. The physical examination demonstrated decreased range of motion of each shoulder, painful range of motion (particularly the right reported to be 9/10) and swelling in the right knee. The injured worker had been cleared to return to his regular duties. The only medication noted was ibuprofen. A full range of motion of the left shoulder was noted in the right shoulder with some limitations of internal rotation. Motor function was 5/5 bilaterally. Motor and sensory intact throughout both upper and lower extremities. Diagnostic imaging studies objectified degenerative, ordinary disease of life changes. Previous treatment included knee arthroscopy and postoperative rehabilitation physical therapy. A request was made for durable medical equipment and was not medically necessary in the pre-authorization process on March 14, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

7 day rental of 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 continuous flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) knee disorders-the pain, clinical measures (electronically cited).

Decision rationale: The guidelines cited above is for the use of such a device to support this in the immediate postoperative period. That time-frame has come. As such, there is no medical necessity for this device.

post - op Physical Therapy for 3X4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: When noting the date of injury, the date of surgery, and the parameters outlined in the post-surgical treatment guidelines, there is support for a brief period of physical therapy after surgery. However, this therapy is to be completed within 12 weeks. As such, this is not clinically indicated. Furthermore, it was noted that multiple sessions of physical therapy had already been completed. Therefore, based on the records presented for review, the medical necessity for this additional therapy has not been established.