

<b>Case Number:</b>	CM14-0055627		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	07/10/2012
<b>Decision Date:</b>	09/05/2014	<b>UR Denial Date:</b>	03/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/25/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California and 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 65 year old female who sustained an injury to her right knee after tripping over a cord in a patient's room; she fell to the floor, sustaining injuries to multiple body parts. Computed tomography scan of the right knee dated 09/20/12 revealed moderately advanced degenerative disease, particularly in the medial compartment; nodular synovial thickening, compatible with synovitis; truncated medial/lateral menisci either postoperative or diffusely degenerative tears; complete anterior cruciate ligament tear suspected; Baker's cyst noted, which could be iatrogenic. The clinical note dated 01/23/14 reported that the injured worker presented with complaints of intractable knee pain. The injured worker continued with pain medications and modified activity. The injured worker stated that her pain was sharp, stabbing, and throbbing in nature. Physical examination demonstrated narrowing of the medial/lateral joint lines, with some cystic areas noted laterally; the diagnostic impression was derangement of the bilateral knees.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) Purchase of Cold Therapy Unit Purchase:** 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 & Workman's Compensation (TWC), Integrated Treatment/Disability Duration Guidelines, Knee and Leg (Acute and Chronic), 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 chapter, Continuous-flow cryotherapy.

**Decision rationale:** The request for 1 purchase of a cold therapy unit is not medically necessary. The previous request was denied on the basis that the guidelines recommend continuous flow therapy for up to 7 days postoperative. The Official Disability Guidelines state that treatment with this modality is recommended as an option after surgery, but not for non-surgical treatment. Postoperative use generally may be up to 7 days, including home use. Given that the request is in excess of the current evidence based guidelines, medical necessity of the request for 1 purchase of a Cold Therapy Unit is not indicated as medically necessary.

**Twenty One (21) day Rental of Continuous Passive Motion (CPM): Upheld**

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

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

**Decision rationale:** The request for a 21 day rental of continuous passive motion (CPM) unit is not medically necessary. The previous request was denied on the basis that continuous passive motion devices for up to 21 days after total knee arthroplasty is recommended; however, as the additional request for a right total knee replacement was deemed not medically necessary, this negates the need for a cold therapy unit and continuous passive motion device. After reviewing the submitted documentation, there was no additional significant objective clinical information that would support reversing the previous adverse determination. Given this, the request for a 21 day rental of Continuous Passive Motion (CPM) unit is not indicated as medically necessary.

**Ten (10) Postoperative Skilled Nursing: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

**Decision rationale:** The request for 10 postoperative skilled nursing visits is not medically necessary. There was no information in the records provided that would indicate the injured worker is home bound and as the requested surgical procedure was deemed not supported, this negates the need for postoperative skilled nursing. There was no additional significant objective clinical information provided that would support the need to reverse the previous adverse determination. Given this, the request for (10) Postoperative Skilled Nursing visits is not indicated as medically necessary.