MAXIMUS Federal Services

Case Number:	CM14-0080458		
Date Assigned:	07/18/2014	Date of Injury:	08/19/2011
Decision Date:	10/02/2014	UR Denial Date:	05/02/2014
Priority:	Standard	Application Received:	06/02/2014

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 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 70-year-old female, who reported injury on 08/19/2011 due to repetitive lifting. The injured worker has diagnoses of right knee internal derangement "medical" meniscus with aggravated degenerative joint disease, ligamentous low back sprain with right radiculopathy sacroiliac joint, history of a 2003 back injury and treatment, and coronary artery disease. Past medical treatment consists of surgery, physical therapy, injections, and medication therapy. An MRI of the right knee was obtained on 10/09/2012, which revealed grade 2 signal in the medial and lateral menisci; a large popliteal fluid collection was also seen in the posterior medial aspect of the knee. No cruciate tear was present. On 03/19/2014, the injured worker complained of right knee pain and slight pain of the low back. Physical examination of the right knee revealed 2+ tenderness to palpation over the medial joint line on the right and 1+ tenderness to palpation over the lateral joint line on the right. There was mild effusion noted over the right knee. McMurray with internal rotation, McMurray with external rotation, patellar grind test, and crepitus with range of motion were all positive on the right. Varus stress test, valgus stress test, Lachman's 30 degrees, anterior drawer test, posterior drawer test, pivot shift test (ACL), reverse pivot shift test (PCL), dial test were all negative on the right. Range of motion of the knees revealed a flexion of 120 degrees and an extension of 2 degrees. Dermatomes testing revealed intact sensation to pinprick and light touch throughout the bilateral lower extremity. Myotomes all tested 5/5 throughout the bilateral lower extremity. Deep tendon reflexes were all 2+ throughout the bilateral extremity. Arterial pulses were 2+ and symmetrical with normal amplitude throughout the bilateral lower extremity. The treatment plan is for the injured worker to continue prescription modalities, have use of a cane, undergo Synvisc injections, and await approval for right total knee replacement. The rationale for request and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-Op Ice Machine Rental Total of 14 days: 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 (updated 03/31/14)

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

Decision rationale: The decision for Post-Op Ice Machine Rental Total of 14 days is not medically necessary. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery for up to 7 days, including home use. The request for 1 ice machine rental (continuous flow cryotherapy) exceeds the recommendations of the Guidelines. 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 has not been fully evaluated. Furthermore, the medical documents provided did not indicate a medical need for the cryotherapy unit that would fall within the guideline limitations, such as surgery. Given the above, the injured worker is not within the ODG. As such, the request for Post-Op Ice Machine Rental Total of 14 days is not medically necessary.

Post-Op Front Wheel Walker: 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 (updated 03/31/14)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: The request for Post-Op Front Wheel Walker is not medically necessary. ODG recommend that walkers or walking aids be used preferably for patients with bilateral knee disease. Almost half of patients with knee pain possess a walking aid. Disability, pain, and age related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. The request as submitted indicates that the front wheel walker is postoperative. However, the submitted report did not indicate that the injured worker had already undergone any type of surgery. Additionally, the rationale was not submitted in the review, warranting the use of a front wheel walker. As such, the request for a Post-Op Front Wheel Walker is not medically necessary.

Post-Op Three in one Commode: 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 (updated 03/31/14)

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

Decision rationale: The request for Post-Op Three in one Commode is not medically necessary. The ODG generally recommend commodes if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. Most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used for convenience in the home. Medical conditions that result in physical limitations for patients may require patient education and modifications to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature. Certain DME toilet items (commodes, bedpans, etc.) are medically necessary if the patient is bed or room confined, and devices such as raised toilet seats, commode chairs, sitz baths, and portable whirlpools may be medically necessary when prescribed as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. Given the above, the injured worker is not within the ODG criteria. There was no indication in the submitted report that the injured worker had any kind of injury, infection, or conditions that resulted in physical limitations. There was also no evidence in the submitted report that the injured worker was bed or room confined. As such, the request for a Post-Op Three in one Commode is not medically necessary.

Post-Op CPM 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 (updated 03/31/14)

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 request for Post-Op CPM unit is not medically necessary. ODG recommend CPM machines for the following: Total knee arthroplasty (revision or primary), anterior cruciate ligament reconstruction (if inpatient care), open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint, 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 atherofibrosis or tendon fibrosis, and/or physical, mental, or behavioral inability to participate in active physical therapy. Given the above, the injured worker is not within the ODG criteria. The submitted report did not indicate that the injured worker had undergone a TKA (revision or primary) or anterior cruciate ligament reconstruction. Furthermore, the request

as submitted did not indicate whether the CPM unit was for initial postoperative use in the hospital or home use. As such, the request is not medically necessary.