

Case Number:	CM14-0104173		
Date Assigned:	09/16/2014	Date of Injury:	08/02/2010
Decision Date:	01/29/2015	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	07/07/2014

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 Surgery and is licensed to practice in Minnesota. 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:

In the injured worker is a female with a history of osteoarthritis of the right knee. There was a work-related injury on August 2, 2010. The current request pertains to arthroscopy of the right knee with major synovectomy and possible chondroplasty, and cryotherapy, CPM for 14 days and physical therapy 12. The date of IMR request is 6/29/2014. There is a utilization review denial of 6/17/2014 noting ODG guidelines which do not recommend arthroscopic surgery for osteoarthritis. Per documentation submitted an MRI scan performed on 3/11/14 revealed prior surgery with likely partial meniscectomy of the posterior horn of the lateral meniscus and lateral retinacular release. There was a large joint effusion with a delicate superior plica and fibrosis adjacent to the plica. There was full-thickness cartilage loss at the lateral facet of the patella, focal full-thickness cartilage loss was noted in the medial compartment as well as the trochlea. Arthroscopy for the same knee was approved on 8/1/2014 and performed on 8/11/2014. There were grade 4 changes in the lateral facet of patella and the lateral trochlear groove. There was a large area of unstable cartilage in the medial femoral condyle which was debrided. Grade 3 and grade 4 changes were present in the medial femoral condyle. The current IMR request pertains to the denial of 6/17/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Polar Care: 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).

Decision rationale: California MTUS guidelines do not address this issue. ODG guidelines are therefore used. Continuous-flow cryotherapy is recommended as an option after surgery. Postoperative use generally may be up to 7 days including home use. It reduces swelling inflammation and pain and cuts down the need for narcotics after surgery. The request as submitted does not specify purchase or rental and also does not indicate the duration of rental. Therefore the request as submitted is not supported by guidelines and the medical necessity is not established.

CPM Right knee x14 days: 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).

Decision rationale: California MTUS guidelines do not address this request. ODG guidelines are therefore used. The criteria for use of continuous passive motion devices at home include total knee arthroplasty or revision, particularly when associated with complex regional pain syndrome extensive arthrofibrosis or tendon fibrosis or physical, mental, or behavioral inability to participate in active physical therapy. It is also indicated in anterior cruciate reconstruction and open reduction and internal fixation of tibial plateau or distal femur fractures. The use after arthroscopy of the knee for debridement of osteoarthritis is not supported by guidelines and as such, the medical necessity is not established.