

<b>Case Number:</b>	CM14-0173157		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	05/31/2012
<b>Decision Date:</b>	01/23/2015	<b>UR Denial Date:</b>	10/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2014

### 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:

The injured worker is a 57 year old female who was injured while at work on May 31, 2012. The result of the injury included swelling and persistent pain of the left shoulder and left knee. Diagnosis include musculoligamentous sprain/strain, cervical strain, status post right shoulder arthroplasty, strain of the left shoulder, rule out impingement syndrome, left shoulder, bilateral carpal tunnel syndrome by clinical evaluation, chondrocalcinosis, left knee, internal derangement, left knee with possible meniscal tear, and history of diabetes mellitus.. X rays of the left shoulder were read as showing slight narrowing of the acromioclavicular joint with a 2.5 mm joint space and the glenohumeral joint with 8.1 mm joint space. There is also calcification that may be either calcific tendonitis or even an avulsion injury of the greater tuberosity that shoots at the outer level of the inferior aspect of the lateral part of the acromion. There is a type 2 acromion. X rays of the left knee showed 8.4 mm of the medial joint space with calcification involving the medial joint space with calcifications involving the medial joint contacting the medial joints both on the femoral side and the tibial side with bridging. There is a level of calcification of the lateral joint with 9.7 mm joint space. There is calcification of the meniscus. It looks like it is extending lateral of the joint line. There is a 6.1 mm of the patellofemoral joint with a flare of the medial femoral condyle. Magnetic resonance imaging of the left shoulder showed subchondral cysts on the articular surface of the acromion, lateral tendinosis, and substantial sub acromial subdeltoid bursitis. Magnetic resonance of the left knee showed intrasubstance degenerative changes are noted in the medial meniscus and there is also a red zone horizontal tear at the level of the body and posterior horn extending medially. Progress reports dated November 21, 2013 showed restricted range of motion of both shoulders. There was pain with range of motion. There was positive crepitation noted over the left knee. Treatment modalities included pain medications and anti-inflammatories. Utilization review

dated February 10, 2014 certified left knee chondroplasty of all three compartments, pre-op clearance, post-op physical therapy three times four, and crutches, partially certified cold therapy for 7 days, partially certified CPM for 21 days, and non-certified Universal therapy wrap and pro-stim 5.0, due to lack of compliance with guideline recommendations.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Associated surgical service: Q-tech cold therapy, QTY: 21 day rental: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC): Knee and Leg, (Acute & Chronic) Procedure Summary last updated 08/25/2014

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

**Decision rationale:** The documentation indicates that 21 day rental of continuous flow cryotherapy unit was certified by UR on 2/10/2014 and the injured worker underwent surgery on 9/11/2014. California MTUS does not address this issue. ODG guidelines recommend use of continuous flow cryotherapy for 7 days after knee surgery. Additional rental was therefore not medically necessary.

**Associated surgical service: purchase of universal therapy wrap and half leg wrap: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC): Knee and Leg, (Acute & Chronic) Procedure Summary last updated 08/25/2014

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

**Decision rationale:** Official Disability Guidelines (ODG) recommends a low level of compression such as with stockings for prevention of deep vein thrombosis. High level compression such as from wraps is indicated for healing leg ulcers, and for controlling lymphedema which is not the case here. Therefore the use of wraps as requested was not medically necessary.

**Associated surgical service: Pro-stim 5.0 with 1 month of supplies, QTY: 30 day rental: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Post Operative Pain (Transcutaneous Electrical Nerve Stimula.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Post-operative pain Page(s): 116.

**Decision rationale:** The documentation indicates UR approval of 21 day rental of a continuous passive motion machine on 2/10/2014. California MTUS does not address this issue. ODG guidelines recommend use of a CPM machine for home use up to a maximum of 17 days. The injured worker underwent surgery on 9/11/2014. The request for CPM rental for an additional 30 days is not supported by guidelines and was not medically necessary.

**Associated surgical service: knee CPM (Continuous Passive Motion) unit, QTY: 30 day rental:** 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 in Workers Compensation (TWC): Knee and Leg, (Acute & Chronic) Procedure Summary last updated 08/25/2014

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

**Decision rationale:** The documentation indicates UR approval of 21 day rental of a continuous passive motion machine on 2/10/2014. California MTUS does not address this issue. ODG guidelines recommend use of a CPM machine for home use up to a maximum of 17 days. The injured worker underwent surgery on 9/11/2014. The request for CPM rental for an additional 30 days is not supported by guidelines and was not medically necessary.

**Associated surgical service: purchase crutches:** 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 in Workers Compensation (TWC): Knee and Leg, (Acute & Chronic) Procedure Summary last updated 08/25/2014

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

**Decision rationale:** The documentation indicates UR approval of crutches as requested on 2/10/2014. The request for another pair of crutches is not medically necessary per guidelines.