

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0203929 | | |
| Date Assigned: | 12/16/2014 | Date of Injury: | 01/06/2005 |
| Decision Date: | 02/25/2015 | UR Denial Date: | 11/18/2014 |
| Priority: | Standard | Application Received: | 12/05/2014 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Orthopedic Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

56 year old male with reported industrial injury to left knee on 1/6/05. Exam note 3/10/14 demonstrates complaints of worsening left knee pain and popping. Objective findings were note for 12 degrees of varus deformity. Exam note 10/22/14 demonstrates that the patient returns for evaluation of left knee pain. Objective findings include morbid obesity. Patient is noted to have antalgic gait with left knee genu varum deformity of 12 degrees. Medial joint line tenderness is noted with impaired motion from 5-95 degrees. 1+ laxity of ACL and PCL was noted with mildly positive patellar apprehension and 4/5 left knee flexion strength. Radiographs demonstrate left knee varus and osteoarthritis.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 post-op physical therapy for the left knee: Overturned

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: Per the CA MTUS/Post Surgical Treatment Guidelines, page 24, arthroplasty of the knee recommends 24 visits over 10 weeks with a post-surgical treatment period of 4 months. The guidelines recommend of the authorized visit initially; therefore, 12 visits are medically necessary. This review presumes that a surgery is planned and will proceed.

Post-op knee immobilizer: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346-347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Chapter

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, Durable Medical Equipment

Decision rationale: CA MTUS/ACOEM guidelines are silent on the issue of durable medical equipment (DME). Per the ODG Knee and Leg section, durable medical equipment is generally defined as a device that meets Medicare definition. The term DME is defined as equipment which:"(1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients;(2) Is primarily and customarily used to serve a medical purpose;(3) Generally is not useful to a person in the absence of illness or injury; &(4) Is appropriate for use in a patient's home."In this case, there is lack of medical necessity for the use of knee immobilizer following total knee replacement being planned. There is no evidence of fracture or instability of the knee in the exam note of 10/22/14 that would meet medical necessity for a knee immobilizer. Therefore, the determination is for not medically necessary and appropriate.

Associated surgical service: 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 (ODG), Knee and Leg Chapter and on the Non-MTUS Medicare National Coverage Determinations Manual

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, Durable medical equipment

Decision rationale: CA MTUS/ACOEM guidelines are silent on the issue of DME. Per the ODG Knee and Leg section, durable medical equipment is generally defined as a device that meets Medicare definition. The term DME is defined as equipment which:"(1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients;(2) Is primarily and customarily used to serve a medical purpose;(3) Generally is not useful to a person in the absence of illness or injury; &(4) Is appropriate for use in a patient's home."In this case there is lack of medical necessity for the use of front wheel walker following total knee replacement being planned. The determination for a front wheel walker occurs following the total joint replacement usually at the request of the physical therapist. As the total joint replacement has

not occurred at the time of the request, the determination is for not medically necessary and appropriate.

Associated surgical service: 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 (ODG), 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, Continuous flow cryotherapy

Decision rationale: CA MTUS/ACOEM is silent on the issue of cryotherapy. According to ODG, Knee and Leg Chapter regarding continuous flow cryotherapy it is a recommended option after surgery but not for nonsurgical treatment. It is recommended for upwards of 7 days postoperatively. In this case, the request has an unspecified amount of days. Therefore, the request is not medically necessary.