MAXIMUS Federal Services

Case Number:	CM14-0207551		
Date Assigned:	12/19/2014	Date of Injury:	08/16/2013
Decision Date:	02/13/2015	UR Denial Date:	11/24/2014
Priority:	Standard	Application Received:	12/11/2014

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 Rehab, has a subspecialty in Interventional Spine Pain Management 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 patient is a 36 year old male with an injury date of 08/16/13. Based on the 11/12/14 progress report, the patient complains of left knee pain at 7/10. The patient has constant pain that is sharp and throbbing with pins-and-needles. The pain is worse when climbing stairs and resting decreases the pain. Examination of left knee shows mild patellofemoral crepitus, but there is a positive patellar compression test. The range of motion of left knee reveals 60 degree extension lag and can bend to 135 degrees. Deep tendon reflexes are physiologic and symmetric at the knee jerks and ankle jerks. The diagnoses are: 1. Left knee chondromalacia patella 2. Left knee synovitis 3. Left knee scar tissue 4. Status post left knee arthroscopy with partial meniscectomy and chondroplasty (01/10/14). The treatment plan is to request for a left knee arthroscopy with synovectomy and chondroplasty. The patient is temporarily totally disabled. The treating physician is requesting DME mobile crutches x2 for left knee and contrast compression therapy device for 7 days post-operatively per 11/12/14 report. The utilization review determination being challenged is dated 11/24/14. The requesting physician provided treatment reports from 05/28/14-11/12/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME Mobile crutches x 2 for left knee: Overturned

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 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 chapter, walking aids (canes, crutches, braces, orthoses, and walkers.

Decision rationale: The patient presents with left knee pain. The request is for DME mobile crutches x2 for left knee. The request was certified by utilization review letter dated 11/24/14 with modification to allow 2 standard crutches. ODG guidelines knee chapter states the following about walking aids (canes, crutches, braces, orthoses, and walkers), "Recommended, as indicated below. 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." In this case, the patient is certified for left knee arthroscopy with synovectomy and chondroplasty on 11/24/14. This seemed to be a prospective postoperative request. Given the patient's post-operative condition with immobilized left knee, use of crutches is reasonable. The request is medically necessary.

Contrast compression therapy device for 7 days Post-Operatively: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: This patient presents with left knee pain. The request is for contrast compression therapy device for 7 days post-operatively. The request is certified by utilization review letter dated 11/24/14 with modification to allow 7 days use of a standard cold therapy unit. MTUS is silent on hot/cold therapy units. ODG guidelines shoulder chapter discuss continuous flow cryotherapy and states "recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." In this case, the patient is certified for left knee arthroscopy with synovectomy and chondroplasty on 11/24/14. The guideline recommends use of hot/cold therapy unit for postoperative treatment, but only up to 7 days. The request is medically necessary.