

<b>Case Number:</b>	CM14-0209133		
<b>Date Assigned:</b>	12/22/2014	<b>Date of Injury:</b>	05/14/2012
<b>Decision Date:</b>	02/20/2015	<b>UR Denial Date:</b>	12/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/15/2014

### 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, Sports Medicine

### 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 53-year-old female who reported an injury on 05/14/2012. The mechanism of injury was unspecified. Her diagnoses include knee degenerative osteoarthritis, knee joint contracture, pain in the left leg joint, thoracic region spinal stenosis, low back syndrome, lumbar radiculitis/thoracic radiculitis, knee sprain/strain of the medial collateral ligament, and wrist sprain/strain. Her past treatments included injections, physical therapy, surgery, and medication. Her surgical history included a left knee arthroscopy, lysis of adhesions, and manipulation under anesthesia on 02/24/2014. On 11/21/2014, the injured worker complained of weakness, clicking, popping, and swelling in the bilateral knees. The injured worker also complained of the low back locking up. Physical examination of the left knee revealed moderate swelling and synovitis with scar tissue medially. The range of motion was indicated to be -3 degrees to 100 degrees. The treatment plan included postoperative CPM machine for 4 weeks and physical therapy evaluation and treatment 3 times a week for 4 weeks. A rationale was not provided. A Request for Authorization form was submitted on 11/25/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-operative CPM Machine for four weeks: 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 Passive Motion (CPM)

**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 passive motion (CPM).

**Decision rationale:** The request for Post operative CPM Machine for four weeks is not medically necessary. According to the Official Disability Guidelines, continuous passive motion machines are recommended for either in hospital use or home use for patients at risk for stiff knee based on demonstrated compliance and measurement improvements. For indication of home use, the criteria include the following: conditions of low postoperative mobility or inability to comply with rehabilitation exercises following a total knee arthroplasty or revision to include complex regional pain syndrome; extensive arthrofibrosis or tendon fibrosis; physical, mental, or behavioral inability to participate in active physical therapy. The injured worker was indicated to have undergone a left knee medial meniscectomy repair with partial lateral meniscectomy and lateral release with chondroplasty of the patella and microfracture of the medial femoral condyle. However, there was a lack of documentation to indicate the injured worker had complex regional pain syndrome, extensive arthrofibrosis or tendon fibrosis, and physical, mental, or behavioral inability to participate in active physical therapies as a condition of low postoperative mobility or inability to comply with rehabilitation exercises following a total knee arthroplasty or revision. Furthermore, there was a lack of documentation that the injured worker had undergone a complete total knee arthroplasty. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

**Physical therapy evaluation and treatment, three times a week for four weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

**Decision rationale:** The request for Physical therapy evaluation and treatment, three times a week for four weeks is not medically necessary. According to the California MTUS Guidelines, physical therapy is indicated for patients with neuralgia, neuritis, and radiculitis for 8 -10 visits over 4 weeks. The clinical documentation indicated the injured worker had completed previous physical therapy sessions. However, there was lack of documentation in regards to objective functional improvement with the previous sessions completed for review and the number of sessions were not specified. In the absence of the above, the request is not supported by the evidence based guidelines. In addition, the request exceeds the suggested number of visits recommended by the guidelines. As such, the request for Physical therapy evaluation and treatment, three times a week for four weeks is not medically necessary.

