

Case Number:	CM14-0023194		
Date Assigned:	05/14/2014	Date of Injury:	03/01/1981
Decision Date:	05/01/2015	UR Denial Date:	01/29/2014
Priority:	Standard	Application Received:	02/24/2014

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 60-year-old male who reported an injury on 03/01/1981. The mechanism of injury was not provided. The documentation of 07/10/2014 revealed the injured worker had failed all non-operative treatments, including anti-inflammatories, the use of a cane, physical therapy, intra-articular injections, and icing. The injured worker's right knee was noted to have varus deformity with 2+ effusions. Range of motion was 5 to 85 degrees. There was pain, crepitus, guarding, and joint line tenderness. The injured worker walked with an antalgic gait. The x-rays in the office revealed joint space narrowing, subchondral sclerosis, and osteophyte formation in all 3 compartments. The diagnosis was end stage right knee osteoarthritis, and the treatment plan included a right knee replacement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: 2 pair thrombo-embolic deterrent (TED) hose stocking:
 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 & Leg (Acute & Chronic).

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 Chapter, Compression Garments.

Decision rationale: The Official Disability Guidelines indicate that compression garments are recommended for the prevention of deep vein thrombosis. This request would be appropriate for the surgical intervention. This review presumes a surgery is planned and will proceed. There is no medical necessity for this request if surgery does not occur. Given the above, the request for associated surgical service 2 pair thrombo-embolic deterrent (TED) hose stocking is medically necessary.

Associated surgical service: 1 front wheel walker: 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 & Leg (Acute & Chronic).

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 Chapter, Walking Aids (canes, crutches, braces, orthoses and walkers).

Decision rationale: The Official Disability Guidelines indicate that disability pain and age related impairments determine the need for a walking aid. The clinical documentation submitted for review indicated the request had been made for a total knee arthroplasty, which would support the necessity for a front wheeled walker. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur. Given the above, the request for associated surgical service 1 front wheel walker is medically necessary.

Associated surgical service: 21-day rental of continuous passive motion (CPM) machine:
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 & Leg (Acute & Chronic).

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 Chapter, Continuous Passive Motion.

Decision rationale: The Official Disability Guidelines indicate for a continuous passive motion device, postoperative use may be considered medically necessary for 4 to 10 days if in hospital for a total knee arthroplasty, and for home use up to 17 days while the injured worker is at risk of a stiff knee and is immobile or unable to bear weight, and under the conditions of low postoperative mobility or an inability to comply with rehabilitation exercises following a total

knee arthroplasty or revision. This may include injured workers with complex regional pain syndrome, extensive arthrofibrosis or tendon fibrosis, or a revision total knee arthroplasty, or physical, mental, or behavioral inability to participate in physical therapy. The clinical documentation submitted for review indicated the injured worker was requesting a right knee arthroplasty. However, there was a lack of documentation indicating a necessity for home use, as it failed to indicate the injured worker had a condition of low postoperative mobility or an inability to comply with rehabilitation exercises. Given the above and the lack of documentation of exceptional factors; the request for associated surgical service: 21-day rental of continuous passive motion (CPM) machine is not medically necessary.

Associated surgical service: 21-day rental of cold therapy unit: 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); Knee & Leg (Acute & Chronic).

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 Chapter, Continuous Flow Cryotherapy.

Decision rationale: The Official Disability Guidelines indicate that a continuous flow cryotherapy unit is appropriate for 7 days postoperatively. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for associated surgical service 21-day rental of cold therapy unit is not medically necessary.