

Case Number:	CM15-0101132		
Date Assigned:	06/03/2015	Date of Injury:	04/29/2013
Decision Date:	07/01/2015	UR Denial Date:	05/09/2015
Priority:	Standard	Application Received:	05/26/2015

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, Indiana, Oregon
 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:

The injured worker is a 68 year old female who sustained an industrial injury on 4/29/13. The mechanism of injury is unclear. Currently she complains of continued left knee pain with feeling of giving way and buckling. On physical exam of the left knee there was tenderness on palpation over the peripatellar region, over the lateral joint line greater than the medial joint line, patellofemoral crepitus, and positive McMurray's test. Medications are Ultram, zanaflex, Soma. Diagnoses include status post left knee partial meniscectomy (4/7/14); osteoarthritis; status post left shoulder humeral head fracture with residual periscapular sprain/ strain, bursitis, tendinitis and degenerative acromioclavicular joint hypertrophy, osteophyte subacromial narrowing, rotator cuff tendinitis, left bicep tenosynovitis with subacromial and subdeltoid bursitis; left wrist and hand sprain/ strain. Diagnostics include diagnostic ultrasound (8/2014) abnormal results. On 5/9/15 Utilization Review evaluated requests for surgical services: continuous passive motion device and cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Service: CPM Machine: Upheld

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) knee.

Decision rationale: CA MTUS/ACOEM is silent on the issue of CPM. According to ODG criteria, CPM is medically necessary postoperatively for 4-10 consecutive days but no more than 21 following total knee arthroplasty. In this case there is no length of rental request. The guideline criteria are not met and the request is not medically necessary.

Associated Surgical Service: Cold Therapy Unit: Upheld

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) knee.

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Knee Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for up to 7 days. In this case no length of rental is specified. As such, the request is not in keeping with guidelines and is not medically necessary.