

Case Number:	CM15-0103792		
Date Assigned:	06/08/2015	Date of Injury:	06/11/2014
Decision Date:	07/10/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	05/29/2015

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

Certification(s)/Specialty: Preventive Medicine, Occupational 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 was a 50-year-old female, who sustained an industrial injury, June 11, 2014. The injured worker previously received the following treatments chiropractic services and right knee MRI. The injured worker was diagnosed with right knee contusion, patellofemoral arthralgia sprain and possible internal derangement with MRI on July 25, 2014, which revealed medial and lateral meniscus. According to progress note of March 6, 2015, the injured workers chief complaint was right knee pain. The injured worker described the pain as continued pain, weakness and swelling. The injured worker reported difficulty with activities of daily living. The injured worker was requesting surgery. The physical exam noted joint pain, muscle spasms, swelling, numbness and gait abnormality. The treatment plan included post-operative rehabilitation therapy, home CPM (continuous range of motion machine), surgical stimulation unit and Cool care cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Supervised post-op rehab therapy quantity 12. 00: Overturned

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: Section 9792. 24. 3. Postsurgical Treatment Guidelines provide for postsurgical therapy as follows: Postsurgical treatment: (Meniscectomy): 12 visits over 12 weeks Postsurgical physical medicine treatment period: 6 months. I am reversing the previous UR decision. The Guidelines allow for 12 visits over 12 weeks of physical therapy; however, 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. Supervised post-op rehab therapy quantity 12. 00 is medically necessary.

Post-Op DME home CMP device (days) quantity 14. 00: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Continuous passive motion (CPM), Knee & Leg (Acute & Chronic).

Decision rationale: According to the Official Disability Guidelines, a continuous passive motion machine may be indicated if the following criteria are met: For home use, up to 17 days after surgery while patients at risk of a stiff knee are immobile or unable to bear weight: (1) Under conditions of low postoperative mobility or inability to comply with rehabilitation exercises following a total knee arthroplasty or revision; this may include patients with: (a) complex regional pain syndrome; (b) extensive arthrofibrosis or tendon fibrosis; or (c) physical, mental, or behavioral inability to participate in active physical therapy. (2) Revision total knee arthroplasty (TKA) would be a better indication than primary TKA, but either OK if #1 applies. Documentation fails to meet the above criteria. Post-Op DME home CMP device (days) quantity 14. 00 is not medically necessary.

Post-op DME Surgi-stim unit (days) quantity 90. 00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792. 20-9792. 26, Page 68.

Decision rationale: Surgi-stim unit is a brand name for a TENS unit. The MTUS does not recommend a TENS unit as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. There is no documentation that a trial period with a rented TENS unit has been completed. Purchase or extended rental of a TENS unit is not medically necessary. Post-op DME Surgi-stim unit (days) quantity 90. 00 is not medically necessary.

Post-op DME: coolcare cold therapy unit (days) quantity 90.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee (Acute & Chronic), Continuous-flow cryotherapy.

Decision rationale: The Official Disability Guidelines recommend continuous-flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. The request exceeds that which is recommended in the Guidelines. Post-op DME: coolcare cold therapy unit (days) quantity 90.00 is not medically necessary.