

Case Number:	CM15-0107669		
Date Assigned:	06/12/2015	Date of Injury:	07/11/2008
Decision Date:	08/18/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	06/04/2015

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: Illinois, California, Texas
 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:

This injured worker is a 53-year-old female who sustained an industrial injury on 7/11/08. Injury occurred when a co-worker was operating a circular knife close to her station and her fingers were lacerated. She was diagnosed with traumatic lacerations of the nerves and tendons of the index, middle, and ring fingers of the right hand. She underwent surgical repair of these complex lacerations with full thickness skin grafting on 7/17/08, and subsequent excision of the radial neuromas in 2010. She was subsequently diagnosed with complex regional pain syndrome of the right upper extremity. A cumulative trauma injury was also noted relative to the hips, knees and low back. The 9/12/14 left knee MRI showed an oblique tear of the posterior horn of the medial meniscus, chondromalacia patella, and lateral patellar tile with subluxation. The 4/27/15 treating physician report cited persistent severe knee pain. She had failed all attempts at conservative treatment, including physical therapy, anti-inflammatory medications, and analgesic medications. Physical exam documented tenderness over the medial and lateral patellar facets, patellar tendons, and medial joint line. Range of motion was 0-90 degrees with patellar crepitus and effusion. There was an abnormal passive patellar translation, abnormal passive patellar tilt and positive medial McMurray's. The treatment plan included arthroscopic left partial medial meniscectomy, possible lateral retinacular release, chondroplasty and debridement. Authorization was also requested for a home continuous passive motion (CPM) device x 14 days rental, a Surgi-Stim unit x 90 days rental, a Cool care cold therapy unit, and home health consultation/ evaluation with home healthcare, and home healthcare occupational/physiotherapy. The 5/15/15 utilization review certified the request for arthroscopic left partial medial

meniscectomy, possible lateral retinacular release, chondroplasty and debridement. The request for home CPM device rental for 14 days was non-certified as there was no guideline support for use and there was limited evidence of extraneous circumstances that support a knee CPM. The request for 90-day rental of a Surgi-Stim unit was non-certified as there was limited evidence presented to suggest that the claimant is unable to tolerate an exercise program and/or had failed post-operative conservative care. The request for 90-day rental of a Cool care cold therapy unit was modified to a standard cold therapy unit for 7 days rental consistent with the Official Disability Guidelines. The request for home health consultation/evaluation with home healthcare, and home healthcare occupational/physiotherapy was modified to one home health consultation/evaluation to determine the need for home care and home healthcare occupational/physiotherapy x 6 visits consistent with Post-Surgical Treatment Guideline recommendations for initial post-op physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home continuous passive motion device (CPM): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, Knee and leg, continuous passive motion device (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 and Leg: Continuous passive motion (CPM).

Decision rationale: The California MTUS does not provide recommendations for this device following knee arthroscopy. The Official Disability Guidelines recommended the use of continuous passive motion (CPM) devices in the home for up to 17 days for patients who have undergone primary or revision total knee arthroplasty. There is no guideline support for the routine or prophylactic use of a CPM unit following knee arthroscopy. Pre-operatively, the patient was reported with full range of motion. There is no compelling reason to support the medical necessity of CPM for this patient. Therefore, this request for CPM (continuous passive motion) is not medically necessary.

Surgi-stim unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: Under consideration is a request for post-operative SurgiStim unit. The SurgiStim unit provides a combination of interferential current (IFC), neuromuscular electrical stimulation (NMES), and galvanic current. The California MTUS guidelines for transcutaneous

electrotherapy do not recommend the use of NMES for post-operative treatment or chronic pain. Galvanic stimulation is considered investigational for all indications. Guidelines indicate that IFC is possibly appropriate if pain is ineffectively control due to diminished effectiveness of medications or due to medication side effects, there is a history of substance abuse, significant post-operative pain limits ability to perform exercise/physical therapy treatment, or the patient is unresponsive to conservative measures. If those criteria are met, then a one-month trial may be appropriate to study effects and functional benefit. Guideline criteria have not been met. There is no indication that standard post-op pain management would be insufficient. There is no documentation that the patient was intolerant or unresponsive to pain medications during the pre-operative period. There was no evidence that post-operative pain will limit this injured worker's ability to perform exercise/physical therapy treatment. If one or more of the individual modalities provided by this multi-modality unit is not supported, then the unit as a whole is not supported. Therefore, this request is not medically necessary.

Coolcare cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338.

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

Decision rationale: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after knee surgery for up to 7 days. The 5/15/15 utilization review decision recommended partial certification of a cold therapy unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.

Home health consultation/evaluations with home healthcare, home health occupational/physiotherapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51, Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: The California MTUS recommends home health services only for otherwise recommended treatment for patients who are homebound, on a part time or intermittent basis. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. The California Post-Surgical Treatment Guidelines for arthroscopic knee surgery suggest a general course of 12 post-operative visits over 12 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be

supported for one-half the general course or 6 visits. Guideline criteria have not been met. There is no evidence that the patient is or will be homebound following knee arthroscopic surgery. There is no clear documentation as to the type of home healthcare services being recommended for this injured worker to establish medical necessity. The 5/15/15 utilization review modified this request to allow one home healthcare evaluation to determine the need for home health care, and allowed for 6 initial occupational/physical therapy sessions. There is no compelling rationale presents to support an additional certification of home health services or occupational/physical therapy at this time. Therefore, this request is not medically necessary.