

<b>Case Number:</b>	CM15-0130697		
<b>Date Assigned:</b>	07/17/2015	<b>Date of Injury:</b>	01/21/2010
<b>Decision Date:</b>	08/17/2015	<b>UR Denial Date:</b>	06/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2015

### 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 53 year old female who sustained an industrial injury on January 21, 2010. She has reported injury to the low back and left knee and has been diagnosed with status post left knee surgery x 2, left knee replacement surgery with poor outcome, right knee meniscal tear secondary to altered gait, lumbar strain, worsening secondary to ongoing altered gait secondary to fair to poor outcome to the left knee surgery x 2, left sacroiliac joint strain and dysfunction secondary to chronic pain secondary to altered gait favoring the left lower extremity, confirmed lumbar instability, confirmed lumbar herniated nucleus pulposus, and piriformis syndrome, left side. Treatment has included medical imaging, medications, surgery, physical therapy, and chiropractic care. The left knee had diffuse swelling, plus 2 effusion. Range of motion was 5-95 degrees with pain and instability, worsening varus-valgus laxity throughout the arc of motion, increasing in flexion. Patella tracks with crepitus. The treatment request included home physical therapy, CPM machine left knee, cold therapy unit left knee 21 day rental, 2 pair ted hose stockings left knee, and skilled nursing visits.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CPM (Continuous Passive Motion) machine for the left knee: 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), Chapter: Knee and Leg - 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.

**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 the request does not specify a length of rental. Based on this the request is not medically necessary.

**Cold therapy unit rental for 21 days: 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), Chapter: Knee and Leg, Continuous-flow cryotherapy.

**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 knee cryotherapy. According to ODG Knee Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for up to 7 days. In this case the requested length exceeds the guideline recommendations and is therefore not medically necessary.

**Two (2) pair TED hose stockings: 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), Chapter: Knee and Leg, Compression garments.

**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 DVT compression garments. The ODG, Knee and Leg section, Compression Garments, summarizes the recommendations of the [REDACTED] and [REDACTED]. It is recommend to use of mechanical compression devices after all major knee surgeries including total hip and total knee replacements. In this case the request is for compression stockings after total knee replacement. There is no documentation of why two pairs are needed instead of one. Based on this the request is not medically necessary.

**Skilled nursing visits (RN) 3 times a week for 3 weeks, quantity: 9 visits: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines Home Health Services.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines home health Page(s): 51.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 51, Home Health Services are recommended only for medical treatment in patients who are home-bound on a part-time or intermittent basis. Medical treatment does not include homemaker services like shopping, cleaning, laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Home health skilled nursing is recommended for wound care or IV antibiotic administration. There is no evidence in the records that the patient is home bound. There are no other substantiating reason why home health services are required. Therefore request is not in keeping with guidelines and is not medically necessary.

**Home physical therapy for the left knee 3 times a week for 2 weeks, quantity: 6 visits:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Postsurgical 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 home physical therapy. According to ODG, Knee and Leg, home health services including physical therapy are only for medical treatment in patients who are home-bound on a part-time or intermittent basis. Medical treatment does not include homemaker services like shopping, cleaning, laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Home health skilled nursing is recommended for wound care or IV antibiotic administration. There is no evidence in the records that the patient is home bound. There is no other substantiating reason why home health physical therapy is required. Therefore request is not medically necessary.