

Case Number:	CM15-0132669		
Date Assigned:	07/20/2015	Date of Injury:	02/19/2004
Decision Date:	08/17/2015	UR Denial Date:	06/12/2015
Priority:	Standard	Application Received:	07/09/2015

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 57 year old female, who sustained an industrial injury on 2/19/2004. She reported slipping and falling onto her hands and knees. Diagnoses have included left knee medial meniscus tear, adhesive capsulitis right knee and status post right knee secondary revision. Treatment to date has included right knee surgery, physical therapy, magnetic resonance imaging (MRI) and medication. According to the orthopedic exam dated 3/24/2015, the injured worker complained of right knee pain associated with locking at times. The left knee was getting worse. She had locking and giving way, affecting activities of daily living. Exam of the left knee revealed range of motion was -5 degrees to 110 degrees. McMurray's test was positive. Authorization was requested for left knee arthroscopy with post-op physical therapy (18 visits), home health aide visits, cold therapy unit (indefinite use) and a continuous passive motion (CPM) device (indefinite use).

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Health Aide, Qty 6 visits: 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 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; "Recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or 'intermittent' basis, generally up to no more than 35 hours per week. 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." In this case, the exam notes from 3/24/15 do not demonstrate the patient is homebound to require the utilization of home health services. Therefore, the request is not medically necessary.

Post operative Physical Therapy, Qty 18: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: According to the CA MTUS/Post Surgical Treatment Guidelines, Knee Meniscectomy, page 24, 12 visits of therapy are recommended after arthroscopy with partial meniscectomy over a 12-week period. The guidelines recommend initially of the 12 visits to be performed. As the request exceeds the initial allowable visits, the request is not medically necessary.

Cold therapy unit, indefinite use, Qty 1: 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.

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for up to 7 days. In this case, there is no specification of length of time requested postoperatively for the cryotherapy unit. Therefore, the determination is not medically necessary.

CPM (continuous passive motion) unit, indefinite use, Qty 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee chapter - Continuous passive motion (CPM) devices.

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 use of CPM after manipulation under anesthesia. ODG Knee is referenced. Inpatient CPM is indicated after revision TKA and sometimes after total knee arthroplasty. Outpatient use is recommended for low ability to comply with an exercise program from physical, mental or behavioral reasons or when excessive fibrosis exists. In this case, the surgery is an arthroscopic meniscectomy. CPM is not medically necessary.