

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0167158 | | |
| Date Assigned: | 09/04/2015 | Date of Injury: | 01/19/2015 |
| Decision Date: | 10/07/2015 | UR Denial Date: | 08/11/2015 |
| Priority: | Standard | Application Received: | 08/25/2015 |

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, Oregon, Washington
 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 55 year old male, who sustained an industrial injury on January 19, 2015, incurring right knee injuries. Right knee Magnetic Resonance Imaging revealed a medial meniscus tear and anterior cruciate ligament degeneration. He was diagnosed with a right knee meniscal tear, and right knee chondromalacia. Treatment included physical therapy, and home exercise program, pain medications and right knee activity restrictions. Currently, the injured worker complained of persistent sharp right knee pain with difficulty ambulating. He noted limited range of motion of the right knee secondary to the chronic pain. He had a recurrent effusion in the right knee and required arthroscopy partial medial meniscectomy, chondroplasty versus micro fracture on the right knee. The treatment plan that was requested for authorization included 12 visits of post-operative physical therapy for the right knee, twice a week for 6 weeks and a rental of continuous passive motion machine for 21 days for the right knee if Micro fracture was performed.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Visits of Post-Operative Physical Therapy for the Right Knee, Twice a Week for 6 Weeks: 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 1-2 of the 12 visits to be performed. As the request exceeds the initial allowable visits, the determination is for non-certification. The request is not medically necessary.

Rental of CPM for 21 Days for the Right Knee if Microfracture is performed: 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 and Leg, CPM Unit.

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

Decision rationale: ODG criteria for the use of a CPM postoperatively are as follows: Criteria for the use of continuous passive motion devices: In the acute hospital setting, postoperative use may be considered medically necessary, for 4-10 consecutive days (no more than 21), for the following surgical procedures: (1) Total knee arthroplasty (revision and primary), (2) Anterior cruciate ligament reconstruction (if inpatient care), (3) Open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint (BlueCross BlueShield, 2005). 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. As this patient is not going to undergo any of the above procedures nor do any of the above conditions exist in this case the recommendation is for non-certification. The request is not medically necessary.