MAXIMUS Federal Services

Case Number:	CM15-0196604		
Date Assigned:	10/12/2015	Date of Injury:	01/12/2014
Decision Date:	12/24/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	10/06/2015

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: Minnesota, Florida
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 46 year old female, who sustained an industrial injury on 1-12-2014. A review of the medical records indicates that the injured worker is undergoing treatment for right medial and lateral meniscal tear status postindustrial injury. On 7-24-2015, the injured worker reported right knee pain, left Achilles tendon pain, left knee pain, back pain, shoulder pain, and wrist and foot pain, rated 8 out of 10, with the right knee swelling, locking, giving way, and buckling with popping and crackling sounds. The Primary Treating Physician's report dated 7-24-2015, noted the injured worker's current medications included Atorvastatin, Ibuprofen, and Acetaminophen-Codeine #3. The right knee physical examination was noted to show patellar tendon and medial joint line tenderness, effusion, and patellar crepitus with positive lateral McMurray's sign. A MRI of the right knee dated 12-8-2014, was noted to show a tear of the anterior horn of the medial meniscus, tear of the body and posterior horn of the lateral meniscus, cartilage delamination of the patellofemoral joint, and no evidence of cruciate or collateral ligament injury. Prior treatments have included Acetaminophen with Codeine, Ibuprofen, physical therapy, acupuncture, bracing, and surgical repair of a ruptures Achilles tendon in May 2014. The treatment plan was noted to include request for arthroscopic right knee surgery with associated services. The request for authorization dated 7-24-2015, requested arthroscopic right partial medial and lateral meniscectomy, chondroplasty and debridement, pre-operative medical clearance, Coolcare cold therapy unit, crutches, post-operative knee brace, supervised post-operative rehabilitative therapy, three times a week, for four weeks (twelve sessions), Continuous Passive Motion (CPM) device for initial period of fourteen days, Surgi-Stim unit for

initial period of ninety days, and DVT prophylaxis involving the use of pneumatic compression device and necessary appliances. The Utilization Review (UR) dated 9-9-2015, certified the requests for arthroscopic right partial medial and lateral meniscectomy, chondroplasty and debridement, pre-operative medical clearance, Coolcare cold therapy unit, crutches, post-operative knee brace, modified the request for supervised post-operative rehabilitative therapy, three times a week, for four weeks (twelve sessions) to certify an initial course of six physical therapy sessions post-operatively, and Surgi-Stim unit for initial period of ninety days to certify a 30 day rental of a TENS unit, and non-certified the requests for Continuous Passive Motion (CPM) device for initial period of fourteen days and DVT prophylaxis involving the use of pneumatic compression device and necessary appliances.

IMR ISSUES, DECISIONS AND RATIONALES

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

Supervised post-operative rehabilitative therapy, three times a week, for four weeks (twelve sessions): Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Surgical Considerations.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Knee.

Decision rationale: The California MTUS postsurgical treatment guidelines indicate 12 visits over 12 weeks for meniscectomy and chondromalacia. The initial course of therapy is one-half of these 12 visits, which is 6. Then with documentation of continuing functional improvement a subsequent course of therapy of the remaining 6 visits may be prescribed. The request as stated is for 12 visits which exceeds the guideline recommendations and as such, the request is not medically necessary.

Continuous Passive Motion (CPM) device for initial period of fourteen 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) Knee and Leg Chapter, Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Knee, Topic: Continuous passive motion.

Decision rationale: The injured worker is undergoing arthroscopy with partial meniscectomy and chondroplasty. ODG guidelines do not recommend continuous passive motion for this surgical procedure. As such, the request for CPM device is not supported. Therefore the request is not medically necessary.

Surgi-Stim unit for initial period of ninety days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: Surgi Stim is a combination of neuromuscular stimulation, H wave, and interferential electrical stimulation. California MTUS chronic pain treatment guidelines do not recommend neuromuscular electrical stimulation. It is used primarily as part of a rehabilitation program following a stroke. Interferential current stimulation is not recommended as there is no quality evidence of effectiveness. H wave stimulation is not recommended as an isolated intervention except for diabetic neuropathy or chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration. As such, the request for Surgi Stim unit is not medically necessary.

DVT Prophylaxis involving the use of pneumatic compression device and necessary appliances: 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) Knee and Leg Chapter, Venous Thrombosis.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Knee, Topic: Venous thrombosis.

Decision rationale: ODG guidelines do not recommend routine use of intermittent pneumatic compression after knee arthroscopy. Patients at high risk of venous thrombosis are placed on pharmacotherapy. The indication for mechanical deep vein thrombosis prophylaxis is in those patients who are undergoing a procedure with increased risk of bleeding. When the bleeding risk subsides, pharmacotherapy is preferred. In this case the documentation provided does not indicate a high risk of deep vein thrombosis. As such, the request for intermittent pneumatic compression is not medically necessary.