

Case Number:	CM15-0200342		
Date Assigned:	10/15/2015	Date of Injury:	09/18/2013
Decision Date:	11/30/2015	UR Denial Date:	10/08/2015
Priority:	Standard	Application Received:	10/13/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 64 year old male who sustained an industrial injury on 9-18-13. The impression is noted as 3 months post implant removal and placement of antibiotic spacer for Enterobacter infection, chronic. Follow up (9-28-15) notes he is 3 months post removal of implants of the right knee and placement of an antibiotic spacer for chronic Enterobacter infection. He is status post surgery of 8 weeks of treatment with intravenous antibiotics, infectious disease consultation and conservative care. Objective findings (9-28-15) include a very restricted degree of motion with fixed flexion of 25 degrees to flexion of about 45 degrees. The plan for revision right total knee arthroplasty. The requested treatment of associated surgical service; purchase of a cold therapy unit was modified to a rental and possible admission to inpatient rehabilitation for 7-10 days was non-certified on 10-8-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: purchase of cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter (online version), 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) Pain Chapter, under Continuous-flow Cryotherapy.

Decision rationale: The patient was injured on 09/18/13 and presents with right knee pain. The request is for a purchase of cold therapy unit. There is no RFA provided and the patient's current work status is not provided. The MTUS and ACOEM Guidelines do not discuss water therapy units. ODG Guidelines, Pain Chapter section, under Continuous-flow Cryotherapy states: Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated. The patient is diagnosed with 3 months post implant removal and placement of antibiotic spacer for Enterobacter infection, chronic. In January of 2015, the patient underwent manipulation of the knee under anesthesia and in May 2015, he underwent an arthroscopic debridement of the knee and lysis of adhesions. The 09/28/15 report states that the provider will "tentatively hold a surgical date for [the patient] in the future for reimplantation" will coordinate scheduling sometime over the next month to 6 weeks. The reason for the request is not provided. Given that the patient is to undergo surgery in the "next month to 6 weeks," a cold therapy unit appears reasonable. The provider is requesting for a purchase of the cold therapy unit. However, ODG Guidelines only allows for up to 7 days home use of the cold therapy unit postoperatively. Therefore, the request is not medically necessary.

Associated surgical service: possible admission to inpatient rehabilitation for 7-10 days:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Hip and Pelvis Chapter (online version), Skilled nursing facility (SNF) care; ODG, Knee Chapter (online version) Skilled nursing facility (SNF) care.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter under Skilled nursing facility (SNF) care Knee & Leg (Acute & Chronic) Chapter under Skilled nursing facility (SNF) care.

Decision rationale: ODG-TWC, Pain (Chronic) Chapter under Skilled nursing facility (SNF) care states: "Recommended if necessary after hospitalization when the patient requires skilled nursing or skilled rehabilitation services, or both, on a 24-hour basis." ODG guidelines, Knee & Leg (Acute & Chronic) Chapter under Skilled nursing facility (SNF) care states: "Recommended if necessary after hospitalization when the patient requires skilled nursing or skilled rehabilitation services." The Criteria for skilled nursing facility care are (1) The patient was hospitalized for at least three days for major or multiple trauma; (2) A physician certifies that the patient needs SNF care for treatment of major or multiple trauma, post-operative significant functional limitations; (3) The patient has a significant new functional limitation such as the inability to ambulate more than 50 feet, or perform activities of daily living (such

as self-care, or eating, or toileting); (4) The patient requires skilled nursing on a daily basis or at least 5 days per week, (5) Treatment is precluded in lower levels of care (e.g. there are no caregivers at home, or the patient cannot manage at home, or the home environment is unsafe; and there are no outpatient management options). The patient is diagnosed with 3 months post implant removal and placement of antibiotic spacer for Enterobacter infection, chronic. In January of 2015, the patient underwent manipulation of the knee under anesthesia and in May 2015, he underwent an arthroscopic debridement of the knee and lysis of adhesions. The 09/28/15 report states that the provider will "tentatively hold a surgical date for [the patient] in the future for reimplantation" will coordinate scheduling sometime over the next month to 6 weeks. The reason for the request is not provided. In this case, there is no indication that the patient will need skilled nursing or skilled rehabilitation services. Therefore, the requested admission to inpatient rehabilitation is not medically necessary.