

Case Number:	CM15-0205836		
Date Assigned:	10/22/2015	Date of Injury:	07/19/2012
Decision Date:	12/10/2015	UR Denial Date:	10/06/2015
Priority:	Standard	Application Received:	10/19/2015

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 55 year old female, who sustained an industrial injury on 7-19-2012. A review of the medical records indicates that the injured worker is undergoing treatment for advanced L4-L5 greater than L5-S1 degenerative disc disease with bilateral central and foraminal stenosis, left lower extremity radiculopathy chronic pain and weakness, status post left total knee arthroplasty with some degree of persistent weakness, and right knee advanced medial compartment osteoarthritis that had failed "maximum nonoperative treatment including bracing, corticosteroid injection, hyaluronic acid injections, nonsteroidal anti-inflammatories, pain medication, physical therapy, and activity modification with weight loss". The Primary Treating Physician's report dated 9-21-2015, noted physical therapy, activity modification, and using some anti-inflammatory medication was noted to have brought the injured worker back her ability to at least stand, walk, and get around. The physical examination was noted to show fairly diffuse lumbar spine tenderness, with the right knee with diffuse tenderness throughout the medial compartment. Prior treatments have included right knee arthroscopy with partial medial meniscectomy and partial lateral meniscectomy 8-15-2013. The treatment plan was noted to include the pursuit of a right total knee arthroplasty. The request for authorization dated 9-23-2015, requested inpatient right total knee arthroplasty, 3 day inpatient stay, 7 day stay at [REDACTED], [REDACTED] blood service 1 pint autologous, pre-operative medical clearance, pre-operative dental clearance, post-operative home physical therapy six (6) visits, post-operative outpatient physical therapy twelve (12) visits, Lovenox for 2 weeks, and post-operative CMP machine twenty-one (21) days. The Utilization Review (UR) dated 10-6-2015, certified the

requests for inpatient right total knee arthroplasty, 3 day inpatient stay, 7 day stay at [REDACTED], [REDACTED], [REDACTED] blood service 1 pint autologous, pre-operative medical clearance, pre-operative dental clearance, post-operative home physical therapy six (6) visits, post-operative outpatient physical therapy twelve (12) visits, and Lovenox for 2 weeks, and modified the request for post-operative CMP machine twenty-one (21) days with certification for seven (7) days and non-certification of the remaining fourteen (14) days.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative CMP machine, twenty-one (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.

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: ODG criteria for the use of continuous passive motion devices for home use include patients at risk of stiffness who are immobile or unable to bear weight. 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 complex regional pain syndrome, extensive arthrofibrosis or tendon fibrosis or physical, mental or behavioral inability to participate in active physical therapy and also for revision total knee arthroplasty. In this case, utilization review has certified 7 days of use of continuous passive motion device. There is no documentation indicating that the injured worker has any of the above conditions. As such, the request for additional 21 days of continuous passive motion is not supported and the medical necessity of the request has not been substantiated, therefore is not medically necessary.