

Case Number:	CM15-0209502		
Date Assigned:	10/28/2015	Date of Injury:	03/02/2014
Decision Date:	12/09/2015	UR Denial Date:	10/13/2015
Priority:	Standard	Application Received:	10/23/2015

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: Emergency Medicine

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 62 year old female, who sustained an industrial injury on 3-2-2014. She reported bilateral knee and left wrist injuries from a trip and fall. Diagnoses include left wrist fracture, right knee fracture, and left shoulder sprain-strain, and left shoulder partial thickness rotator cuff tear. Treatments to date include activity modification, right knee sleeve, and medication therapy. On 8-17-15, she complained of ongoing symptoms in the left wrist, knees, and shoulder. The physical examination documented right patellar tendon tenderness, crepitus, decreased range of motion, and positive McMurray's sings. The right knee MRI dated 6-6-15, noted to reveal medial and lateral meniscus tears. The plan of care included right knee arthroscopic repair. The appeal requested authorization for Durable Medical Equipment (DME) 14 day rental of home continuous passive motion (CPM) device, remaining 60 days rental of Surgistim Unit, and purchase of Coolcare cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

14 day rental of home CPM device: 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Continuous Passive, Motion.

Decision rationale: The requested 14-day rental of home CPM device, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS) does not address this request. Official Disability Guidelines (ODG), Knee & Leg chapter, Continuous Passive Motion, state: "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." The injured worker has ongoing symptoms in the left wrist, knees, and shoulder. The physical examination documented right patellar tendon tenderness, crepitus, decreased range of motion, and positive McMurray's signs. The right knee MRI dated 6-6-15, noted to reveal medial and lateral meniscus tears. The plan of care included right knee arthroscopic repair. The treating physician has not documented the medical necessity for use of this device beyond the referenced guideline recommended time period. The criteria noted above not having been met, 14-day rental of home CPM device is not medically necessary.

90 day rental of SurgiStim unit: 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): Electrical stimulators (E-stim).

Decision rationale: The requested 14-day rental of home CPM device is not medically necessary. Chronic pain medical treatment guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009), page 114 of 127. Transcutaneous electrotherapy noted "TENS, post operative pain (transcutaneous electrical nerve stimulation) Recommended as a treatment option for acute post-operative pain in the first 30 days post-surgery. Transcutaneous electrical nerve stimulation (TENS) appears to be most effective for mild to moderate thoracotomy pain. (Solak, 2007) (Erdogan, 2005) It has been shown to be of lesser effect, or not at all for other orthopedic surgical procedures. (Breit, 2004) (Rosenquist 2003) The proposed necessity of the unit should be documented upon request. Rental would be preferred over purchase during this 30-day period." The injured worker has ongoing symptoms in the left wrist, knees, and shoulder. The physical examination documented right patellar tendon tenderness, crepitus, decreased range of

motion, and positive McMurray's signs. The right knee MRI dated 6-6-15, noted to reveal medial and lateral meniscus tears. The plan of care included right knee arthroscopic repair. The treating physician has not documented the medical necessity for use of this device beyond the referenced guideline recommended time period. The criteria noted above not having been met, 90-day rental of SurgiStim unit is not medically necessary.

Purchase of Coolcare cold therapy unit: 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, 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) Shoulder, Knee, Continuous Flow Cryotherapy.

Decision rationale: The requested Purchase of Coolcare cold therapy unit is not medically necessary. CA MTUS is silent on this issue and Official Disability Guidelines, Shoulder, Knee, Continuous Flow Cryotherapy, recommends up to 7 days post-op cold therapy. In a post-operative setting, cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The injured worker has ongoing symptoms in the left wrist, knees, and shoulder. The physical examination documented right patellar tendon tenderness, crepitus, decreased range of motion, and positive McMurray's signs. The right knee MRI dated 6-6-15, noted to reveal medial and lateral meniscus tears. The plan of care included right knee arthroscopic repair. The treating physician did not document the medical necessity for continued use of cold therapy beyond the guideline recommended seven days usage. The criteria noted above not having been met, Purchase of Coolcare cold therapy unit is not medically necessary.