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| Case Number: | CM15-0217564 | | |
| Date Assigned: | 11/09/2015 | Date of Injury: | 08/25/2013 |
| Decision Date: | 12/21/2015 | UR Denial Date: | 10/30/2015 |
| Priority: | Standard | Application Received: | 11/04/2015 |

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: Illinois, California, Texas
 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 54-year-old female who sustained an industrial injury on 8/25/13. She underwent a left knee partial medial meniscectomy on 10/8/13 and a partial medial meniscectomy and chondroplasty of the medial femoral condyle and trochlea on 12/4/14. The 9/14/15 treating physician report cited persistent significant left knee symptoms. She was unable to work as her job required extensive standing and walking. Extensive conservative treatment had included oral medications, physical therapy, unloader brace, injections, activity modification, and arthroscopic surgery. She had underlying arthrosis as well as an osteochondral injury of the medial tibial plateau. Left knee exam documented positive effusion, medial joint line tenderness, no instability, range of motion 0-105 degrees and crepitation with motion. X-rays were obtained and showed a medial tibial plateau osteochondral injury, significant narrowing of the medial aspect of the medial joint space, and patellofemoral degenerative joint disease. Authorization was requested for a left total knee replacement with associated surgical services continuous passive motion (CPM) machine rental, and cryotherapy rental. The 10/30/15 utilization review certified the request for a left total knee replacement. The request for a CPM machine rental was modified to a 21-day rental consistent with the Official Disability Guidelines. The request for a cryotherapy unit rental was modified to a 7-day rental consistent with the Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Service: Continuous Passive Motion Machine: 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 Official Disability Guidelines (ODG) Knee and Leg: Continuous passive motion (CPM).

Decision rationale: The California MTUS does not provide recommendations for this device following total knee replacement. The Official Disability Guidelines state that the use of a CPM device may be considered medically necessary in the acute hospital setting for 4 to 10 days (no more than 21 days) following total knee replacement and for home use up to 17 days while the patient at risk of a stiff knee is immobile or unable to bear weight following a primary or revision total knee arthroplasty. However, this request is for an unknown length of use, which is not consistent with guidelines. The 10/30/15 utilization review modified this request for an unspecified duration of CPM machine rental to 21 days consistent with guidelines. There was no compelling rationale presented to support the medical necessity of additional certification at this time. Therefore, this request is not medically necessary.

Associated Surgical Service: Cryotherapy: 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 Official Disability Guidelines (ODG) Knee and Leg: Continuous flow cryotherapy.

Decision rationale: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after knee surgery for up to 7 days. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use, which is not consistent with guidelines. The 10/30/15 utilization review decision recommended partial certification of a cold therapy unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.