

Case Number:	CM15-0031871		
Date Assigned:	02/25/2015	Date of Injury:	07/20/2004
Decision Date:	04/10/2015	UR Denial Date:	01/22/2015
Priority:	Standard	Application Received:	02/20/2015

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 69 year old male who sustained an industrial injury on 7/20/04. The injured worker reported symptoms in the bilateral knees. The diagnoses included arthritis, knee (bilateral) and knee pain. Treatments to date include cortisone injection to the left knee and nonsteroidal anti-inflammatory drugs. In a progress note dated 11/11/14 the treating provider reports the injured worker was with "bilateral knee pain that is constant and sharp." On 1/22/15 Utilization Review non-certified the request for Continuous Passive Motion knee and Continuous Passive Motion pad kit/knee universal (rental or purchase not provided). The MTUS, ACOEM Guidelines, (or ODG) was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

CPM knee and CPM pad kit/knee universal (rental or purchase not provided): 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 Passive Motion Devices.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Knee chapter, under Continuous Passive Motion (CPM).

Decision rationale: The patient presents with bilateral knee pain. The request is for CPM knee and CPM universal (rental or purchase not provided). Patient is status post left total knee arthroplasty, date unspecified. Patient's treatments include medication, home exercise program and physical therapy. Patient's diagnosis include left knee degenerative joint disease, status post left total knee arthroplasty with computer navigation. Per 02/04/15 progress report, patient's medications include Viagra, Trazodone, Cochicine, Acetaminophen, Uloric, Omeprazole, Gabapentin, Fluticasone and Celebrex. Patient's work status was not specified. ODG Knee chapter, under Continuous Passive Motion (CPM), criteria for the use of continuous passive motion devices states: "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 treater does not discuss the request but the patient is s/p left TKR. ODG allows up to 17 days of CPM use following knee replacement and the use of the unit may be appropriate for this patient. However, the request does not specify for how long this unit is to be used. Given the guidelines time limitation, the treater must specify the duration. The request IS NOT medically necessary.