

Case Number:	CM15-0055593		
Date Assigned:	04/15/2015	Date of Injury:	12/16/2014
Decision Date:	06/02/2015	UR Denial Date:	03/02/2015
Priority:	Standard	Application Received:	03/24/2015

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: Orthopedic Surgery, Sports 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 mechanism of injury was the injured worker was assisting an intoxicated patient in the hospital and the patient became combative. The injured worker wrestled the patient to the gurney and twisted his right knee. The documentation indicated the injured worker would be undergoing surgical intervention. The injured worker is a 36 year old male, who sustained an industrial injury on 12/16/2014. The current diagnoses are medial meniscus tear of the knee, chondromalacia patellae, and old disruption of anterior cruciate ligament. According to the progress report dated 1/29/2015, the injured worker complains of right knee pain and instability. Additionally, he reports popping and very limited activity. The current medications are Bupropion. Treatment to date has included medication management, X-rays, ice, knee immobilizer, and MRI studies. The plan of care includes cold therapy unit for right knee, NMES unit for right knee, electrical stimulator supplies (2 leads per month), DVT prevention unit for right knee, and brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-Operative DJ Rom Cold Therapy Unit for the Right Knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter.

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

Decision rationale: The Official Disability Guidelines indicate that continuous flow cryotherapy is recommended for up to 7 days postoperatively. The surgical intervention was found to be medically necessary. This request would be supported for 7 days. However, the request as submitted failed to indicate whether the unit was for rental or purchase, and if for rental the duration of use. Given the above, the request for post-operative DJ Rom cold therapy unit for the right knee is not medically necessary.

Post-Operative NMES Unit for the Right Knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: The California MTUS guidelines do not recommend Neuromuscular electrical stimulation (NMES devices) as there is no evidence to support its use in chronic pain. The clinical documentation submitted for review failed to provide a rationale for the NMES unit. The request as submitted failed to indicate the duration of use, and whether the unit was for rental or purchase. Given the above, the request for post-operative NMES unit for the right knee is not medically necessary.

Electrical Stimulator supplies 2 lead per month: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-Operative DVT prevention Unit for the Right Knee: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC; ODG Treatment; Integrated Treatment/ Disability Duration Guidelines, Knee and Leg Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Venous Thrombosis, Compression Garments.

Decision rationale: The Official Disability Guidelines indicate that injured workers should be assessed to be at risk for deep venous thrombosis. If found to be at risk, the injured worker should be considered for oral anticoagulation therapy. Additionally, the guidelines recommend the postoperative use of compression hose to prevent deep venous thrombosis. The clinical documentation submitted for review failed to provide documentation the injured worker was found to be at risk for deep venous thrombosis. There was a lack of documentation indicating the injured worker could not utilize compression garments for the prevention of deep venous thrombosis. Additionally, the request as submitted failed to indicate the duration of use and whether the unit was for rental or purchase. Given the above, the request for post-op DVT prevention unit for the right knee is not medically necessary.