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| Case Number: | CM13-0037528 | | |
| Date Assigned: | 12/13/2013 | Date of Injury: | 12/17/1998 |
| Decision Date: | 02/07/2014 | UR Denial Date: | 10/03/2013 |
| Priority: | Standard | Application Received: | 10/23/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in physical medicine and rehabilitation and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This male sustained an injury to the left knee on 12/17/98 while employed by [REDACTED]. Requests under consideration include Post-op physical therapy for the left knee, 3x/wks. for 4 weeks and DME cold therapy unit for 10-14 day rental. Report dated 9/26/13 from [REDACTED] noted pre-op examination for scheduled left knee surgery with post-operative physical therapy and cold therapy unit. The patient has undergone two previous ACL reconstructions along with debridement and meniscectomy. He was certified for left knee arthroscopy debridement and possible meniscectomy which was apparently performed on 9/30/13. Request for post-op therapy was partially-certified on 10/3/13 for an initial 6 visits with further consideration pending results and the cold therapy unit was partially-certified for 7 days rental citing guidelines criteria.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op physical therapy for the left knee, 3xper week for 4 wks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines, Postsurgical Treatment Guidelines Page(s): 24-25.

Decision rationale: This male sustained an injury to the left knee on 12/17/98 while employed by [REDACTED]. Requests under consideration include Post-op physical therapy for the left knee, 3x/wks. for 4 weeks and DME cold therapy unit for 10-14 day rental. Report dated 9/26/13 from [REDACTED] noted pre-op examination for scheduled left knee surgery with post-operative physical therapy and cold therapy unit. The patient has undergone two previous ACL reconstructions along with debridement and meniscectomy. He was certified for left knee arthroscopy debridement and possible meniscectomy which was apparently performed on 9/30/13. Request for post-op therapy was partially-certified on 10/3/13 for an initial 6 visits with further consideration pending results and the cold therapy unit was partially-certified for 7 days rental citing guidelines criteria. The Chronic Pain Guidelines, post-operative therapy allow for 12 visits over 12 weeks for arthroscopic debridement and possible meniscectomy over a postsurgical physical medicine treatment period of 6 months. Submitted reports have not adequately demonstrated the indication to support further physical therapy beyond the initial guidelines criteria. The patient's arthroscopy is now over 4 months without documented functional limitations or complications to allow for additional physical therapy. There is no reported functional improvement from treatment already rendered nor what limitations are still evident for further therapy. The Post-op physical therapy for the left knee, 3xper week for 4 wks. (CPT codes 97001,97010,97039,97140) is not medically necessary and appropriate.

DME 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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Continuous-Flow Cryotherapy, page 292

Decision rationale: This male sustained an injury to the left knee on 12/17/98 while employed [REDACTED]. Requests under consideration include Post-op physical therapy for the left knee, 3x/wks. for 4 weeks and DME cold therapy unit for 10-14 day rental. Report dated 9/26/13 from [REDACTED] noted pre-op examination for scheduled left knee surgery with post-operative physical therapy and cold therapy unit. The patient has undergone two previous ACL reconstructions along with debridement and meniscectomy. He was certified for left knee arthroscopy debridement and possible meniscectomy which was apparently performed on 9/30/13. Request for post-op therapy was partially-certified on 10/3/13 for an initial 6 visits with further consideration pending results and the cold therapy unit was partially-certified for 7 days rental citing guidelines criteria. MTUS Guidelines is silent on specific use of cold compression therapy with pad and wrap, but does recommend standard cold pack for post exercise. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post knee surgery; however, limits the use for 7-day post-operative period as efficacy has not been proven after. Submitted reports have not demonstrated medical necessity outside guidelines criteria. The DME cold therapy unit (PCT code E0218), 10-14 day rental is not medically necessary and appropriate.

