

<b>Case Number:</b>	CM14-0164658		
<b>Date Assigned:</b>	10/09/2014	<b>Date of Injury:</b>	04/04/2011
<b>Decision Date:</b>	11/12/2014	<b>UR Denial Date:</b>	09/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. 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/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:

The injured worker is a 59-year-old male with a date of injury of 10/01/1986. The injury occurred while he was employed as a feeder driver. The mechanism of injury was not documented. Past surgical history was positive for right knee arthroscopic surgeries in 1992, 2004, and on 4/4/11. The injured worker underwent right total knee replacement with computer navigation on 1/10/14. He attended 24 sessions of post-op physical therapy. The 7/29/14 orthopedic report cited grade 1/10 right knee pain. The injured worker was walking 50 minutes a day and was off all assistive devices, he had tried playing golf, and had difficulty walking hills. He had not yet returned to work. Physical exam documented well healed right knee incision with painless range of motion from 0-130 degrees. He had an even gait and was neurovascularly intact. The treatment plan recommended continued conditioning and endurance. The 8/14/14 physical therapy evaluation cited minimal pain with walking on level ground. His main complaint was severe lateral knee pain with full knee flexion and instability going downhill or stairs. He was able to squat to lift objects. Current problem list included myofascial restrictions to the posterior hip/lateral knee, flexibility deficits in the hip especially in external rotation, mild patellofemoral joint restriction, lower extremity weakness, impaired joint integrity at the tibiofemoral joint anterior/posterior, and gait dysfunction. Functional limitations were noted in walking on uneven surfaces, descending stairs, walking downhill, and working as a truck driver. A physical exam documented full knee flexion, excessive crepitus with tibial translation, and positive anterior drawer test. The treatment plan recommended physical therapy 2x4. A request was submitted for manipulation under anesthesia of the right knee, 12 post-op physical therapy visits, cold compression unit, cane, and continuous passive motion machine. The 9/27/14 utilization review denied the request for continuous passive motion for the right knee as the associated manipulation under anesthesia was not medically necessary.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Durable medical equipment (CPM machine 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 Knee & Leg (Acute & Chronic) 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 and Leg, Continuous passive motion (CPM)

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) does not provide recommendations for this device following total knee replacement. The Official Disability Guidelines state that the use of a continuous passive motion device may be considered medically necessary in the acute hospital setting for 4 to 10 days (no more than 21 days) following total knee arthroplasty (revision and primary), anterior cruciate ligament reconstruction, or open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint. Continuous passive motion is typically supported for home use up to 17 days while the injured worker at risk of a stiff knee is immobile or unable to bear weight following a primary or revision total knee arthroplasty. Guideline criteria have not been met. Guidelines generally do not support the use of continuous passive motion for home care following a manipulation under anesthesia. This request does not include duration of use which would be required to establish medical necessity. There is no compelling reason to support the medical necessity of continuous passive motion for this injured worker in the absence of guideline support. The manipulation has been felt to be not medically necessary. Therefore, this request is not medically necessary.