

Case Number:	CM14-0028635		
Date Assigned:	06/16/2014	Date of Injury:	02/06/1996
Decision Date:	09/23/2014	UR Denial Date:	02/07/2014
Priority:	Standard	Application Received:	03/06/2014

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 73-year-old male who reported an injury on 02/06/1996. The mechanism of injury was not specifically stated. The current diagnoses include patellofemoral osteoarthritis of the left knee and status post right knee patellofemoral resurfacing. The injured worker was evaluated on 09/23/2013. It is noted that the injured worker underwent a left knee surgery in 2001. Previous conservative treatment is noted to include physical therapy, steroid injections, and viscosupplementation injections. The injured worker presented with persistent pain. Physical examination revealed tenderness in the retropatellar area with a positive compression test. X-rays obtained in the office on that date indicated adequate medial and lateral joint spaces. Treatment recommendations included a patellofemoral arthroplasty for the left knee. A Request for Authorization form was then submitted on 09/26/2013 for a left knee resurfacing procedure, Lovenox injections, home health RN visits, physical therapy, a continuous passive motion device, a cold therapy unit, and medical clearance. It is noted that the injured worker underwent an MRI of the left knee on 08/30/2011, which indicated postsurgical change of the medial meniscus, medial compartment chondromalacia, patellofemoral chondromalacia, joint effusion, Baker's cyst, and scarring in the Hoffa's fat pad anteromedially.

IMR ISSUES, DECISIONS AND RATIONALES

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

CONTINUOUS PASSIVE MOTION (CPM) 21 DAYS RENTAL FOR LEFT 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 - TREATMENT FOR WORKERS COMPENSATION, KNEE AND LEG PROCEDURE SUMMARY LAST UPDATE 01/09/2013.

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 Passive Motion.

Decision rationale: The Official Disability Guidelines state in the acute hospital setting, postoperative use of a continuous passive motion may be considered medically necessary for 4 to 10 consecutive days (no more than 21) for a total knee arthroplasty, ACL reconstruction, or an Open Reduction Internal Fixation (ORIF) of the tibial plateau or distal femur fracture. The injured worker does not maintain any of the above-mentioned diagnoses. The injured worker was issued authorization for a left knee resurfacing surgery. This surgical procedure is not included in the indications for a continuous passive motion device following surgery. Therefore, the request for Continuous Passive Motion (CPM) 21 days rental for left knee is not medically necessary and appropriate.

HOME RN VISIT 2 X 3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines HOME HEALTH SERVICES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

Decision rationale: The California MTUS Guidelines recommend home health services for otherwise recommended medical treatment for patients who are homebound on a part time or intermittent basis, generally up to no more than 35 hours per week. The injured worker was issued authorization for a left knee resurfacing surgery. The patient was also issued authorization for an initial RN evaluation to assess the patient's condition following surgery. Pending the results of the evaluation, additional home health visits are not indicated at this time. As such, the request for Home RN Visit 2 X 3 is not medically necessary and appropriate.