

<b>Case Number:</b>	CM14-0013607		
<b>Date Assigned:</b>	02/26/2014	<b>Date of Injury:</b>	12/13/2011
<b>Decision Date:</b>	07/15/2015	<b>UR Denial Date:</b>	01/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2014

### 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. 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 48-year-old male who sustained an industrial injury on 12/13/11. Injury occurred relative to a rear-end motor vehicle accident. The injured worker was diagnosed with cervical myofascial sprain, cervical degenerative disc disease with neuroforaminal narrowing, lumbar myofascial sprain, and contusion of right knee, rule out medial meniscal tear. Past medical history was positive for hyperlipidemia. Conservative treatment included 24 physical therapy visits, anti-inflammatory medications, anti-inflammatory medication, home exercise program, 3 arthrocentesis procedures in the right knee, and one steroid injection. The 12/5/13 right knee MRI impression documented a horizontal linear signal in the posterior horn and body of the medial meniscus, not extending to the articular surface, and small joint effusion. The 1/8/14 treating physician report cited right knee aching pain, aggravated by bending and climbing stairs. Physical exam documented normal alignment and flexibility, no instability, mild effusion, and positive McMurray's test. Right knee range of motion was 0-135 degrees. There was maximum tenderness in the medial joint line, patella, medial retinacular, and patellar tendon. The diagnosis included right meniscal tear and chondromalacia patella. Authorization was requested for right knee arthroscopy with partial medial meniscectomy. Associated surgical requests included post-operative cold therapy unit x 14 days, post-operative physical therapy two times per week for 4 to 6 weeks, and post-operative CPM (continuous passive motion) for 14 days. The 1/23/14 utilization review certified the request for right knee arthroscopy with partial medial meniscectomy. The request for post-operative cold therapy was modified to 7-day rental of a cold therapy unit. The request for continuous passive motion was non-certified noting the

Official Disability Guidelines. The request for physical therapy 2x4-6 was modified to physical therapy 2x3 consistent with Post-Surgical Treatment Guidelines for initial post-operative treatment.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Post Operative Cold Therapy for 14 days: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, 2nd Edition, 2008, Knee Complaints, pages 1015-1017 and the Official Disability Guidelines, Knee & Leg (last updated 01/09/2014), Continuous-flow Cryotherapy.

**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 flow cryotherapy.

**Decision rationale:** The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous-flow cryotherapy is an option for up to 7 days in the post-operative setting following knee surgery. The 1/23/14 utilization review decision recommended partial certification of a cryotherapy unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.

#### **Post operative physical therapy 2 times per week for 4-6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

**Decision rationale:** The California Post-Surgical Treatment Guidelines for meniscectomy suggest a general course of 12 post-operative visits over 12 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 6 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. The 1/23/14 utilization review recommended partial certification of 6 initial post-op physical therapy visits consistent with guidelines. There is no compelling reason submitted to support the medical necessity of care beyond guideline recommendations and the care already certified. Therefore, this request is not medically necessary.

#### **Post Operative CPM (Continuous Passive Motion) for 14 days: 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 (last updated 01/09/2014), Continuous Passive Motion (CPM).

**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 MTUS does not provide recommendations for this device following knee arthroscopy. The Official Disability Guidelines recommended the use of continuous passive motion (CPM) devices in the home for up to 17 days for patients who have undergone primary or revision total knee arthroplasty. There is no guideline support for the routine or prophylactic use of a CPM unit following knee arthroscopy. Pre-operatively, the patient was reported with full functional range of motion. There is no compelling reason to support the medical necessity of CPM for this patient. Therefore, this request is not medically necessary.