

Case Number:	CM14-0157473		
Date Assigned:	09/30/2014	Date of Injury:	10/15/2013
Decision Date:	01/02/2015	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/25/2014

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 General Preventive Medicine and is licensed to practice in Indiana. 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:

This employee is a 40 year old female with date of injury of 10/15/2013. A review of the medical records indicates that the patient is undergoing treatment for left knee tear of ACL and MML. Subjective complaints include continued pain in the left knee with intermittent popping, locking, and giving away. Objective findings include tenderness over the anterior medial aspect of the left knee with slight swelling, effusion; mild crepitation and slightly positive posterior; and anterior drawer test, Lachman's test, and pivot shift test; McMurray and Apley's test were positive; and limited range of motion. Treatment has included Norco and Naprosyn. The utilization review dated 8/25/2014 non-certified post-operative cold therapy for 1 week and continuous passive motion.

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 one week: 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), 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) Low Back (Lumbar and Thoracic), Lumbar Support and Non-MTUS

<http://www.deroyal.com/medicalproducts/orthopedics/product.aspx?id=pc-temptherapy-coldtherunit>

Decision rationale: MTUS is silent on the use of cold therapy units. Official Disability Guidelines (ODG) for heat/cold packs states "Recommended as an option for acute pain: At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007)". The uses of devices that continually circulate a cooled solution via a refrigeration machine have not been shown to provide a significant benefit over ice packs. Furthermore, the request for surgery was non-certified. Therefore, the request for post-operative cold therapy for one week is not medically necessary.

Post-operative continuous passive motion: 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), 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, Continuous Passive Motion (CPM)

Decision rationale: Regarding Continuous Passive Motion, MTUS is silent, but Official Disability Guidelines (ODG) states the following: "Criteria for the use of continuous passive motion devices: In the acute hospital setting, postoperative use may be considered medically necessary, for 4-10 consecutive days (no more than 21), for the following surgical procedures: (1) Total knee arthroplasty (revision and primary); (2) Anterior cruciate ligament reconstruction (if inpatient care); (3) Open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint (BlueCross BlueShield, 2005). For home use, up to 17 days after surgery while patients at risk of a stiff knee are immobile or unable to bear weight: (1) Under conditions of low postoperative mobility or inability to comply with rehabilitation exercises following a total knee arthroplasty or revision; this may include patients with: (a) complex regional pain syndrome; (b) extensive arthrofibrosis or tendon fibrosis; or (c) physical, mental, or behavioral inability to participate in active physical therapy. (2) Revision total knee arthroplasty (TKA) would be a better indication than primary TKA, but either OK if #1 applies." The request for surgery was non-certified; therefore, the request for post-operative continuous passive motion is not medically necessary.