

Case Number:	CM14-0213136		
Date Assigned:	12/30/2014	Date of Injury:	07/22/2012
Decision Date:	03/10/2015	UR Denial Date:	12/05/2014
Priority:	Standard	Application Received:	12/19/2014

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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 55-year-old male who reported an injury on 12/15/2011. The mechanism of injury was falling down on his left side. His diagnoses included right medial meniscal tear, right knee injury. Past treatments have included physical therapy, a home exercise program, activity modification, and anti-inflammatory medication. Diagnostic studies have included an unofficial ultrasound study of the bilateral knees on 10/28/2013, that revealed bilateral complex medial meniscal tear of the posterior horn, grade 3 signal. The surgical history included a left knee arthroscopic medial meniscectomy, chondroplasty, and debridement on 04/23/2014. The progress note dated 10/13/2014 documented the injured worker had complaint of right knee pain. His physical exam findings included range of motion to the right knee flexion measured at 120 degrees and extension at 180 degrees, positive for tenderness in the medial epicondyle, medial joint line, and medial tibia. There was effusion noted to the right knee, a positive medial McMurray's sign. A current medication list was not provided. The treatment plan included advising the injured worker as to the diagnosis, prognosis, indications, complications, and alternatives to conservative management versus surgical intervention, and a request for knee surgery. The rationale for the request is pain management. The Request for Authorization form is signed and dated 10/13/2014 in the medical record.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: continuous passive motion (CPM) device x 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 (ODG)

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: The request for continuous passive motion (CPM device) x 14 days is not medically necessary. The Official Disability Guidelines state that for home use, the CPM device is recommended up to 17 days after surgery, while patients at risk of a stiff knee, are immobile, or unable to bear weight 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 complex regional pain syndrome, extensive arthrofibrosis, or tendon fibrosis or physical, mental, or behavioral inability to participate in active physical therapy. As the injured worker does not demonstrate these behaviors, the request for the continuous passive motion device x14 days is not supported. Therefore, the request is not medically necessary.

Associated surgical service: surgi-stim 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 (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) knee, Electrical stimulators (E-stim).

Decision rationale: The request for surgi-stim unit is not medically necessary. The Official Disability Guidelines state "that there should be a specific machine, and upon investigation there are several surgi-stim unit varieties. Without further information, the specific unit is unable to be researched. However, the guidelines state the AHRQ comparative effectiveness review of physical therapy for knee arthritis concluded that e-stim improved global assessment, but worsened pain and did not improve disability, health reception, and gait, joint, transfer, and composite function measures." Therefore, the request for the surgi-stim unit is not supported. The request is not medically necessary.

Associated surgical service: cool care 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 (ODG)

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-flow cryotherapy.

Decision rationale: The request for cool care cold therapy unit is not medical necessary. The Official Disability Guidelines state "that continuous flow cryotherapy is recommended as an option after surgery. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. However, the effect on more frequently treated acute injuries has not been fully evaluated." The request does not reflect how long the unit would be needed, nor does it include the placement of the unit. The request for associated surgical service: cool care cold therapy unit is not supported at this time. The request is not medically necessary.

Associated surgical service: supervised post-operative rehabilitative therapy 3x4.: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

Decision rationale: The request for associated surgical service: supervised post-operative rehabilitative therapy 3x4 is not medically necessary. The California MTUS Postsurgical Treatment Guidelines indicate that postoperative rehabilitation is recommended. The recommendation for tear of medial/lateral cartilage/meniscus of knee is recommended for a total of postsurgical treatments up to 12 visits. However, the initial recommended visits would be 6 trial visits. The request does not include the body part the therapy is being requested for. The request for associated surgical service: supervised post-operative rehabilitative therapy 3x4 is not supported by the documentation submitted for review. The request is not medically necessary.