

Case Number:	CM15-0017388		
Date Assigned:	02/05/2015	Date of Injury:	09/01/2010
Decision Date:	03/30/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	01/29/2015

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: Physical Medicine & Rehabilitation

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 61 year old female sustained a work related injury on 09/01/2010. According to a progress report dated 12/17/2014, the injured worker was seen for right knee pain. She has had prior right knee surgery, but she rated pain 7-8 on a scale of 0-10. She failed conservative treatment such as anti-inflammatories, physical therapy and pain medication and wished to undergo total knee arthroplasty. X-rays of the right knee showed severe osteoarthritis of the right knee with bone on bone changes, osteophyte formation, and subchondral sclerosis. The right knee had lateral compartment severe wear. The provider's assessment was noted as severe right knee valgus degenerative joint disease. On 12/30/2014, Utilization Review modified continuous passive motion machine purchase, physical therapy 3 times a week for 4 weeks and a 30 day rental of cold therapy unit. Guidelines cited for the request included CA MTUS and Official Disability Guidelines, Knee/Leg Chapter. The decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continuous passive motion machine purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Shoulder Chapter, continuous passive motion devices

Decision rationale: The 60 year old patient presents with right knee pain, rated at 7-8/10, as per progress report dated 12/17/14. The request is for Continuous Passive Motion Machine Purchase. There is no RFA for this case, and the patient's date of injury is 09/01/10. The patient is status post right knee arthroscopy in 2012 and shoulder arthroscopy in 2002. X-ray of the right knee, as per progress report dated 12/17/14, reveals osteoarthritis, osteophyte formation, and subchondral sclerosis. In progress report dated 10/22/14, the patient complains of left knee pain, and has been diagnosed with left knee mild osteoarthritis. The patient has been allowed to return to modified work, as per progress report dated 09/16/14. The ACOEM and MTUS do not discuss Continuous passive motion devices. ODG Shoulder Chapter has the following regarding continuous passive motion devices, "Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week." ODG further states, "Rotator cuff tears: Not recommended after shoulder surgery or for nonsurgical treatment." In this case, none of the progress reports discuss the request for continuous passive motion machine purchase. The patient is status post shoulder arthroscopy in 2002 and continues to suffer from pain in the affected area. Physical examination, as per progress report dated 09/16/14, revealed positive Neer and Hawkins impingement signs and tenderness in subacromial bursa and shoulder girdle musculature along with limited range of motion. MRI of the right shoulder, dated 02/25/12, noted a SLAP lesion, partial rotator cuff tear, and AC joint arthrosis and tendinitis. ODG Guidelines do not recommend CPM for patients with shoulder rotator cuff problems. Therefore, the requested continuous passive motion unit IS NOT medically necessary.

Physical Therapy 3 times a week for 4 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

Decision rationale: The 60 year old patient presents with right knee pain, rated at 7-8/10, as per progress report dated 12/17/14. The request is for Physical Therapy 3 Times A Week For 4 Weeks. There is no RFA for this case, and the patient's date of injury is 09/01/10. The patient is status post right knee arthroscopy in 2012 and shoulder arthroscopy in 2002. X-ray of the right knee, as per progress report dated 12/17/14, reveals osteoarthritis, osteophyte formation, and subchondral sclerosis. In progress report dated 10/22/14, the patient complains of left knee pain, and has been diagnosed with left knee mild osteoarthritis. The patient has been allowed to return to modified work, as per progress report dated 09/16/14. MTUS guidelines pages 98 to 99 state that for patients with "myalgia and myositis, 9 to 10 sessions over 8 weeks are allowed, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits over 4 weeks are allowed." In this case, none of the progress reports discuss this request. However, AME report dated 02/26/13, states that the patient's treating physician has requested for 12 sessions of physical therapy along with Synvisc

injection for the patient's knee. The progress reports do not document any functional improvement or reduction in pain due to prior therapy. Additionally, MTUS only allows 8-10 sessions of physical therapy in patients who are not within the post-operative time frame. Hence, the request IS NOT medically necessary.

30 day rental of cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines chapter 'Knee and Leg (Acute & Chronic)' and topic 'Continuous-flow cryotherapy'

Decision rationale: The 60 year old patient presents with right knee pain, rated at 7-8/10, as per progress report dated 12/17/14. The request is for 30 Days Rental Of Cold Therapy Unit. There is no RFA for this case, and the patient's date of injury is 09/01/10. The patient is status post right knee arthroscopy in 2012 and shoulder arthroscopy in 2002. X-ray of the right knee, as per progress report dated 12/17/14, reveals osteoarthritis, osteophyte formation, and subchondral sclerosis. In progress report dated 10/22/14, the patient complains of left knee pain, and has been diagnosed with left knee mild osteoarthritis. The patient has been allowed to return to modified work, as per progress report dated 09/16/14. ODG guidelines, chapter 'Knee and Leg (Acute & Chronic)' and topic 'Continuous-flow cryotherapy', states that cold therapy units are "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." In this case, none of the progress reports discuss the need for a cold therapy unit. In progress report dated 12/17/14, the treater states that the patient wishes to undergo total knee arthroplasty. However, it is not clear if the patient has been evaluated and authorized for the surgery or not. Nonetheless, ODG supports for the use of cold therapy unit only during the first seven days in operative cases, and the unit is not recommended for chronic pain. Hence, the request for 30 day rental IS NOT medically necessary.