

Case Number:	CM15-0118616		
Date Assigned:	06/26/2015	Date of Injury:	07/18/2011
Decision Date:	07/30/2015	UR Denial Date:	06/03/2015
Priority:	Standard	Application Received:	06/19/2015

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, Indiana, New York
Certification(s)/Specialty: Internal 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 67 year old male who sustained an industrial injury on July 18, 2011. He has reported injury to the cervical spine, bilateral shoulder, bilateral wrist, and bilateral knee and has been diagnosed with bilateral knee tricompartmental osteoarthritis, status post left total knee replacement, bilateral chronic shoulder rotator cuff syndrome, and rule out tear, bilateral hand pain, non-orthopedic issues, and bilateral feet pain. Treatment has included medications management, activity restrictions, and physical therapy, surgery, and cortisone injections. He rates his cervical pain a 4/10, bilateral shoulder pain a 6/10, bilateral wrist pain a 3/10, and right knee pain a 9/10. Examination of the right knee revealed tenderness over the medial aspect. There was audible crepitus on passive range of motion. Range of motion was 0 to 90 degrees. He had varus alignment. Examination of the left knee revealed audible crepitus on passive range of motion. The treatment request included polar care, DVT machine, and CPM rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Polar Care: 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) Shoulder section, Continuous flow cryotherapy.

Decision rationale: Pursuant to the Official Disability Guidelines, the request for associated surgical services polar care is not medically necessary. Continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Post-operative use may be for up to seven days, including home use. In the post-operative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling and narcotic use; however the effect on more frequently treated acute injuries has not been fully evaluated. In this case, the injured worker's working diagnoses are bilateral knee tri-compartmental osteoarthritis, status post left total knee replacement; bilateral chronic shoulder rotator cuff syndrome; bilateral hand pain; and bilateral feet pain. The injured worker is scheduled for a right total knee arthroplasty. A continuous flow cryotherapy unit is indicated, but the treating provider did not specify the length of time for its use. Continuous flow cryotherapy is indicated for seven days. Consequently, absent clinical documentation with a timeframe for use (polar care), this request is not medically necessary.

Associated surgical service: Deep Vein Thrombosis (DVT) Machine: 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), Treatment in Workers Comp, 18th Edition, 2013, Updates Knee and Leg.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, the request for associated surgical services DVT machine is not medically necessary. The ACOEM states "patient at home application of heat or cold packs may be used before or after exercises and aren't effective as those performed by a therapist." The Official Disability Guidelines state, "not generally recommended in the shoulder." Main thrombosis and pulmonary embolism events are common complications following lower extremity orthopedic surgery, but are rare following upper extremity surgery, especially shoulder arthroscopy. The preoperative workup should include risk factors for DVT. In this case, the injured worker's working diagnoses are bilateral knee tri-compartmental osteoarthritis, status post left total knee replacement; bilateral chronic shoulder rotator cuff syndrome; bilateral hand pain; and bilateral feet pain. The injured worker is scheduled for a right total knee arthroplasty. There is no documentation in the medical record of risk factors for deep vein thrombophlebitis. The injured worker's weight is 213 pounds. There are no prior DVT's, pulmonary emboli heart or lung complaints. The DVT machine is clinically indicated for the in hospital (acute-care) period. There is no clinical indication based on risk factors for the DVT machine use once discharged. Based on the clinical information in the medical record and the peer-reviewed evidence-based guidelines, the request for associated surgical services DVT machine is not medically necessary.

Associated surgical service: Continuous passive motion (CPM): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee: Criteria for the use of continuous passive motion devices.

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 section, CPM.

Decision rationale: Pursuant to the Official Disability Guidelines, the request for associated surgical services Continuous passive motion (CPM) is not medically necessary. Continuous passive motion is recommended, for in-hospital use. Routine home use of CPM has minimal benefit. Criteria for the use of continuous passive motion devices include: acute hospital setting postoperatively 4-10 days (no more than 21) for total knee arthroplasty. In this case, the injured worker's working diagnoses are bilateral knee tri- compartmental osteoarthritis, status post left total knee replacement; bilateral chronic shoulder rotator cuff syndrome; bilateral hand pain; and bilateral feet pain. The injured worker is scheduled for a right total knee arthroplasty. The guidelines recommend 4-10 consecutive day postoperative period of use. The treating provider did not discuss the time duration in the request for authorization or the medical record. Although the request for continuous passive motion is clinically indicated, and open ended rental/purchase is not clinically indicated. Based on the clinical information in the medical record, the peer-reviewed evidence-based guidelines and a 10-day rental, the request for associated surgical service continuous passive motion (CPM) is not medically necessary.