

Case Number:	CM15-0174565		
Date Assigned:	09/16/2015	Date of Injury:	09/24/2014
Decision Date:	12/01/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/04/2015

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: New York, California
 Certification(s)/Specialty: Emergency 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 63 year old male, who sustained an industrial injury on 9-24-14. The documentation noted on 8-12-15 the injured worker is still having difficulty going up and downstairs and has a substantial gait abnormality. The injured workers pain is substantial and describes his knee pain as a 7 to 8 out of ten on his right and status post arthroplasty is at 0 or 1 out of ten. Examination revealed left knee with near full range of motion and he lacks full extension by about 3 degrees, flexion 120 degrees and there is tender palpate the medial femoral condyle anteriorly and no posterior medical joint line tenderness. The diagnoses have included status post left knee arthroscopy, meniscectomy, chondroplasty, microfracture medial femoral condyle articular defect and degenerative arthrosis with grade 4 defect medically, post op almost 7 months out, condition worsening. Treatment to date has included cortisone injections helped the injured workers knee pain for about a week or 2 and left knee arthroscopic on 1-22-15. The original utilization review (8-28-15) had a request for 12 post op physical therapy sessions 3x4 that was modified to allow for 8 post-op physical therapy sessions 2x4. The request for 6 home physical therapy 2x3 was modified to allow for 4 home physical therapy 2x2. The request for magnetic resonance imaging (MRI) zimmer patient specific instruments (PSI) protocol was non- certified. The request for associated service, cold therapy unit machine was modified to allow a cold therapy unit machine for a 7 day rental post-operatively and the request for associated service, continuous passive motion machine was modified to allow for a continuous passive motion machine 21 day rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Post op physical therapy sessions 3x4: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Knee.

Decision rationale: A left total knee arthroplasty is planned for this IW. The CA MTUS guideline support 24 post-operative physical therapy visits over the course of 10 weeks. The request for 12 visits adheres to these guidelines. This request, in combination with the request for 6 home visit physical therapy session, is less than the recommended 24 sessions. As such, the request is determined medically necessary. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

6 Home physical therapy 2x3: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Knee.

Decision rationale: A left total knee arthroplasty is planned for this IW. The CA MTUS guideline support 24 post-operative physical therapy visits over the course of 10 weeks. The request for 6 home physical therapy visits adheres to these guidelines. This request, in combination with the request for 12 physical therapy session, is less than the recommended 24 sessions. As such, the request is determined medically necessary. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Associated service: CTU 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), Knee & Leg chapter - 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: According the above cited reference, 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 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 (e.g., muscle strains and contusions) has not been fully evaluated. The current request does have a time limit for the anticipated use of this unit. As the recommendations limit use to 7 days, the request without limits is not medically necessary.

Associated service: CPM machine: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter.

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.

Decision rationale: According to ODG guidelines, CPM are indicated below, for in-hospital use, or for home use in patients at risk of a stiff knee, based on demonstrated compliance and measured improvements, but the beneficial effects over regular PT may be small. Routine home use of CPM has minimal benefit. Criteria for use include: 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. 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. It is not clear from the request if the machine is requested for in hospital request or home use. Additionally, it is not clear the requested duration of use. Without these details or support of the guidelines, the request is determined not medically necessary.