

<b>Case Number:</b>	CM15-0092679		
<b>Date Assigned:</b>	05/19/2015	<b>Date of Injury:</b>	09/16/2012
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	04/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 34-year-old male who sustained an accepted industrial injury on 9/16/12. Injury occurred while he was assisting to break up a riot. He underwent right knee partial medial meniscectomy on 1/19/13. The 11/26/14 right knee MR arthrogram revealed a right medial meniscus tear and chondromalacia of the patellofemoral joint. The 3/13/15 orthopedic report indicated that the injured worker was seen for a second opinion surgical consultation. He reported grade 7/10 bilateral knee pain. Right shoulder exam documented range of motion 0-135 degrees, positive medial joint line tenderness, positive effusion, positive medial McMurray's sign, normal strength, and no instability. The diagnoses included status post failed right arthroscopic partial medial meniscectomy. The injured worker was deemed an excellent candidate for arthroscopic right partial medial meniscectomy, chondroplasty and debridement. Authorization was also requested for twelve (12) supervised post-operative rehabilitative therapy to reduce pain and swelling, as well as range of motion and strength; home continuous passive motion (CPM) device for an initial period of fourteen (14) days to assist in restoring range of motion; a post-operative knee brace; a Surgi-Stim unit for an initial period of ninety (90) days to assist in muscle re-education; and a Coolcare cold therapy unit to assist in managing post-operative swelling and pain. The 4/30/15 utilization review certified the request for right knee arthroscopy partial medial meniscectomy, chondroplasty, and debridement. The request for 12 sessions of supervised post-operative rehabilitative therapy was modified to 6 post-operative therapy sessions consistent with Post-Surgical Treatment Guidelines. The request for Surgi-Stim unit for 90 days was modified to a TENS unit for 30 days consistent with guidelines for

transcutaneous electrical therapy. The request for a Coolcare cold therapy unit was modified to 7-day rental of a cold therapy unit consistent with the Official Disability Guidelines. The request for home continuous passive motion unit for 14 days was non-certified as there was no guideline support for continuous passive motion status post arthroscopic surgery. The request for a post-operative knee brace was non-certified as there was no documentation of instability for which bracing would be supported by the MTUS guidelines.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Post-operative supervised rehabilitative therapy, twelve (12) sessions (3x4): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25.

**Decision rationale:** The California Post-Surgical Treatment Guidelines for chondroplasty suggest a general course of 12 post-operative visits over 12 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 6 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. The 4/30/15 utilization review modified this request to 6 initial visits consistent with guideline recommendations. There is no compelling rationale presented to support the medical necessity of additional certification at this time. Therefore, this request is not medically necessary.

**Associated surgical service: Home continuous passive motion (CPM) device; initial period of fourteen (14) days: 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 (ODG) Knee and Leg: Continuous passive motion (CPM).

**Decision rationale:** The California MTUS does not provide recommendations for this device following knee arthroscopy. The Official Disability Guidelines recommended the use of continuous passive motion (CPM) devices in the home for up to 17 days for patients who have undergone primary or revision total knee arthroplasty. There is no guideline support for the routine or prophylactic use of a CPM unit following knee arthroscopy. Pre-operatively, the patient was reported with full range of motion. There is no compelling reason to support the medical necessity of CPM for this patient. Therefore, this request is not medically necessary.

**Post-operative knee brace: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Knee braces.

**Decision rationale:** The California MTUS guidelines state that a knee brace can be used for patellar instability, anterior cruciate ligament tear, or medial collateral ligament instability. In general, custom braces are not supported over pre-fabricated braces unless specific indications are met. The Official Disability Guidelines support the use of pre-fabricated braces for the following conditions: knee instability, ligament insufficiency/deficiency, reconstructed ligament, articular defect repair, avascular necrosis, meniscal cartilage repair, painful failed total knee arthroplasty, painful high tibial osteotomy, painful unicompartmental osteoarthritis, or tibial plateau fracture. Guideline criteria have been met. This patient is undergoing a repeat meniscal surgery. The use of a brace in the post-operative period is reasonable for pain control and stability. Therefore, this request is medically necessary.

**Associated surgical service: Surgi-Stim unit; Initial period of ninety (90) days: 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 Transcutaneous electrotherapy Page(s): 114-121.

**Decision rationale:** The SurgiStim unit provides a combination of interferential current, neuromuscular electrical stimulation (NMES), and galvanic current. The California MTUS guidelines for transcutaneous electrotherapy do not recommend the use of NMES in the treatment of chronic pain. Galvanic stimulation is considered investigational for all indications. Guidelines suggest that interferential current is not recommended as an isolated intervention. Patient selection criteria is provided if interferential stimulation is to be used despite lack of guideline support and includes ineffective pain control due to diminished effectiveness of medications, intolerance of medications, history of substance abuse, post-operative pain limiting functional ability, and failure to respond to conservative measures. Guideline criteria have not been met. There is no indication that standard post-op pain management would be insufficient. There is no documentation that the patient was intolerant or unresponsive to pain medications during the pre-operative period. If one or more of the individual modalities provided by this multi-modality unit is not supported, then the unit as a whole is not supported. Therefore, this request is not medically necessary.

**Associated surgical service: Coolcare 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 (ODG) Knee Chapter.

**Decision rationale:** The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous-flow cryotherapy is an option for up to 7 days in the post-operative setting following knee surgery. The 4/30/15 utilization review decision recommended partial certification of a cryotherapy unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.