

Case Number:	CM15-0094142		
Date Assigned:	05/20/2015	Date of Injury:	07/31/2013
Decision Date:	07/08/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	05/15/2015

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 51-year-old male who sustained an industrial injury on 7/31/13. The mechanism of injury was not documented. The 2/23/15 left knee MRI impression documented joint effusion, and horizontal tear of the posterior horn of the medial meniscus with mild chondromalacia of the medial compartment. There were mild osteoarthritic changes and the medial and lateral compartments, and mild chondromalacia patella. The 3/5/15 treating physician report cited on-going left knee pain with popping, grinding, and buckling. He reported increased pain with prolonged driving. Physical exam documented medial joint line tenderness, positive McMurray's, crepitus with motion, and positive grind test. Range of motion was 0-125 degrees. The diagnosis was horizontal tear of the posterior horn of the left medial meniscus. The injured worker was deemed an excellent candidate for arthroscopic left partial medial meniscectomy, chondroplasty, and debridement. The treating physician also requested authorization for home continuous passive motion device, crutches, postoperative knee brace, Surgi-Stim unit, and Coolcare cold therapy unit. The 5/12/15 utilization review certified the request for left knee arthroscopic partial medial meniscectomy, chondroplasty and debridement with standard pre-operative medical clearance, post-operative physical therapy, 21 day use of crutches, and 14-day use of a Coolcare cold therapy unit. The request for home continuous passive motion device was non-certified as there was no concern regarding loss of motion. The request for indefinite use of crutches was non-certified, noting certification of 21-day use. The request for indefinite use of a Coolcare cold therapy unit was non-certified, noting certification of 14-day use. The request for a

Surgi-Stim unit was non-certified as there was no evidence of need. The request for post-operative knee brace was non-certified as there was no necessity for bracing in this procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home continuous passive motion device: 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, Continuous passive motion.

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.

Crutches indefinite use: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: The California MTUS guidelines support the use of crutches for partial weight bearing for patients with knee complaints for 1 to 2 weeks. The Official Disability Guidelines state that disability, pain, and age-related impairments determine the need for a walking aid. Assistive devices can reduce pain and allow for functional mobility. The post-operative use of crutches is consistent with guidelines. The 5/12/15 utilization review certified a separate request for 21-day rental of crutches. There is no compelling reason to support the medical necessity of additional certification beyond 21 days. Therefore, this request is not medically necessary.

Post-operative knee brace indefinite use: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346-347.

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 and 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 injured worker has been certified for a meniscectomy and chondroplasty. There is guideline support for the use of a brace for meniscal cartilage and articular defect repair. The use of a brace in this case would be reasonable for pain control and stability. Therefore, this request is medically necessary.

Surgi-stim unit for 90 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

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.

Coolcare cold therapy unit indefinite use: 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, 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: 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 5/12/15 utilization review certified a separate request for Coolcare cold therapy unit for 14-day rental. There is no compelling reason in the medical records to support the additional use of a cold therapy unit beyond the 14 days already certified. Therefore, this request is not medically necessary.