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| Case Number: | CM15-0099431 | | |
| Date Assigned: | 07/22/2015 | Date of Injury: | 10/02/2001 |
| Decision Date: | 08/24/2015 | UR Denial Date: | 05/18/2015 |
| Priority: | Standard | Application Received: | 05/22/2015 |

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, Hawaii
 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:

The injured worker is a 65 year old male who sustained an industrial injury on 10/2/01 when he lifted an object and then snapped his head up too fast resulting in a sharp, hot pain in the neck that lasted over one hour. He was medically evaluated, given medication, physical therapy and had an MRI of the cervical spine revealing a herniated disc at C3-4 on the right and C5-6 on the left. He currently complains of headaches which are craniocervical/ occipital with paresthesia, dizziness with spinning, sweating and fainting; neck pain with a pain level of 4/10; intermittent right knee pain (6/10); psychological symptoms of anxiety, depression and stress. On physical exam there was tenderness in bilateral occipital regions right more than left with decreased range of motion and positive Spurling's and cervical decompression tests bilaterally. He has problems in all aspects of activities of daily living including basic activities. Medications were butalbital, Neurontin, Norco, and Benicar. Diagnoses include muscle contraction headaches and dizziness; occipital neuralgia; temporomandibular joint pain; status post anterior cervical fusion (with improvement); probable history of postsurgical encephalopathy; emotional distress; sleep disturbance; cognitive impairment; gastrointestinal problems; cervical radiculopathy; neuropathic pain in bilateral upper extremities; distal left vertebral aneurysm; right knee sprain/strain, rule out tear; internal derangement of the right knee. Treatments to date include medications; physical therapy; bilateral knee braces. Diagnostics include computed tomography of the neck (3/9/15) showing large fusiform aneurysm with no evidence of dissection, arachnoid cyst along the anterior aspect of the temporal lobe; computed tomography angiography of the intracranial arteries (3/9/15) reports as above; MRI of the right knee (4/17/15) showing a tear of

the proximal anterior cruciate ligament and osteoarthritis. He was to have a right knee arthroscopy, chondroplasty and possible meniscectomy and in the progress note dated 4/28/15 the treating provider's plan of care includes requests for cold therapy unit for 30 days; post-operative physical therapy for the right knee totaling 24 visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: 30 day use of a cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg (Acute & Chronic): Continuous-flow cryotherapy (2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous-flow Cryotherapy.

Decision rationale: The patient presents with pain affecting the right knee. The current request is for associated surgical service: 30-day use of a cold therapy unit. The treating physician states in the report dated 4/28/15, "I am recommending the following devices for home use to help the patient recover from their surgical procedure. Cold therapy unit for 30 days." (570B) The right knee arthroscopy, chondroplasty, and possible meniscectomy was certified and the patient had the surgery on 6/3/15. The ODG guidelines state, "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, the treating physician has requested a time period which exceeds the recommended guideline of 7 days. The current request is not medically necessary.

24 post operative physical therapy visits: Overturned

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): 24-25.

Decision rationale: The patient presents with pain affecting the right knee. The current request is for 24 post-operative physical therapy visits. The treating physician states in the report dated 4/28/15, "Postoperative rehabilitation physical therapy for the right knee totaling 24 visits for post-surgical treatment." (570B) The right knee arthroscopy, chondroplasty, and possible meniscectomy was certified and the patient had the surgery on 6/3/15. The MTUS Post-Surgical guidelines support up to 24 visits of physical therapy after knee arthroscopy. In this case, the treating physician has documented that the patient is in the post-surgical state and requested an amount that is within the MTUS guidelines. The current request is medically necessary.

