

<b>Case Number:</b>	CM13-0001182		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	02/15/2013
<b>Decision Date:</b>	01/24/2014	<b>UR Denial Date:</b>	06/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 48 year old claimant was injured on 02/15/13 and has a diagnosis of status post left knee arthroscopy which was done on 06/07/13. The surgery was for partial medial meniscectomy, chondroplasty, excision of large soft tissue mass of the superomedial suprapatellar region, release of medial suprapatellar plica, and extensive synovectomy of the suprapatellar area as well as anterior to anterior cruciate ligament. Postoperatively there were requests for an electrical stimulator and left knee ThermoCooler System rental for 4 weeks. The determination was for a modified approval of the ThermoCooler to allow for a 7 day rental and then the electrical stimulator unit was denied as not medically necessary. Postoperative care also included medication and physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left knee thermal cooler system rental times 4 weeks (hot, cold and compression system):**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, postoperative cryotherapy: 2010.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-339. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Continuous-flow cryotherapy.

**Decision rationale:** CA MTUS does not specifically address the use of a cryotherapy or cooling unit in the postoperative setting; they only address the use of hot/cold packs. In looking to Official Disability Guidelines, the use of a cryotherapy unit or as requested in this case a ThermoCool unit, is allowed in the postoperative setting for a period of 7 days postoperative. The recommendation as indicated in the initial review allowing for a modification and a seven day rental would be appropriate. A request for a 4 week rental of the unit would not be considered as medically necessary.

**Thermacooler Pad/Wrap:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**EMS unit rental x 1 month:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee Chapter Guidelines, NMES.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, NMES.

**Decision rationale:** CA MTUS addresses electrical stimulation in the pain setting however it does not address the specific use of EMS as requested in this case. In looking to Official Disability Guidelines the guidelines for neuromuscular stimulation state "Recommended as an option only for short-term use during rehabilitation early in the postoperative period following major knee surgeries". In this case the claimant underwent an arthroscopic procedure which would not be considered as a major knee surgery such that would warrant the use of this intervention as requested. The clinical information in this case does not support the requested EMS rental for one month as the guidelines allow for it only in certain settings such as ACL reconstruction.

**Electrodes (four per pack x2):** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Batteries x 2:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Set up and delivery:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.