

Case Number:	CM13-0013912		
Date Assigned:	10/11/2013	Date of Injury:	02/21/2007
Decision Date:	09/12/2014	UR Denial Date:	08/01/2013
Priority:	Standard	Application Received:	08/28/2013

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. The expert reviewer is Board Certified in Family Medicine 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 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/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 is a 49 year old female patient who reported an industrial injury on 2/21/2007, over 7 years ago, to the knee attributed to the performance of her job tasks. The patient has been authorized a right knee arthroscopy with a partial lateral meniscectomy. The patient was prescribed a Polar Unit purchase as DME for the post operative care of the knee s/p arthroscopy.

IMR ISSUES, DECISIONS AND RATIONALES

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

POST OP DME: POLAR UNIT PURCHASE: 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): 38. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg chapter--arthroscopy; meniscectomy; Low back chapter--Cold/heat packs.

Decision rationale: The use of the cold circulation units are recommended by evidence based guidelines for hospital use but not for home use. There is no demonstrated medical necessity for this cold therapy unit with appliance (Polar Unit) to be provided to the patient subsequent to the surgical intervention to the knee for home treatment as opposed to the conventional treatment with cold packs. The medical necessity of the DME for the home treatment of the patient was not

supported with objective evidence to support medical necessity. There is no objective evidence to support the home use of the requested cold therapy system as opposed to the customary RICE for the treatment of pain and inflammation after the initially recommended seven days of home therapy with a cold therapy unit such as the Polar Unit with knee/leg pad. There was no clinical documentation provided to support the medical necessity of the requested DME in excess of the recommendations of the California MTUS. The use of a cold circulation pump post operatively is recommended for up to seven (7) days and not recommended for longer durations of time. The cold therapy units are not medically necessary for the treatment of the knee post operatively as alternatives for the delivery of heat and cold to the knee are readily available. The request for authorization of the cold therapy by name brand is not supported with objective medically based evidence to support medical necessity. There is no provided objective evidence to support the medical necessity of the compression as opposed to the more conventional methods for the delivery of cold for the cited surgical intervention rehabilitation. The request is not medically necessary and appropriate.