

<b>Case Number:</b>	CM13-0023953		
<b>Date Assigned:</b>	11/20/2013	<b>Date of Injury:</b>	04/18/2013
<b>Decision Date:</b>	01/21/2014	<b>UR Denial Date:</b>	08/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/13/2013

### 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 Physical Medicine & Rehabilitation and Pain 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 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:

The patient is a 39-year-old female who reported an injury on 04/05/2013, after she pivoted on her foot and felt a pop in the back of her knee which resulted in immediate onset of pain. On 06/04/2013, the patient underwent an MRI of the right knee which revealed an oblique tear of the body of the medial meniscus, a tear of the medial meniscal root with a 5.4 mm medial extrusion, full thickness chondral defects at the medial femoral condyle with adjacent marrow edema, tricompartmental chondromalacia, mild medial displacement of the patella with respect to the intercondylar groove of the femur with increasing flexion. There was also tricompartmental osteoarthritis noted but there were no other significant findings. After receiving initial treatment at the [REDACTED], the patient was placed on medications, and advised to rest while using ice, compression and elevating the knee. The patient was also provided with chiropractic care for a compensable back injury; but continued to describe her pain as sharp, stabbing, and radiating to the leg. On 09/17/2013, the patient subsequently underwent a right knee arthroscopic major synovectomy/3 compartments, abrasion arthroplasty/chondroplasty to the patellofemoral joint with removal of an osteophyte to the lower pole of the patella. The physician is now requesting a cold therapy unit for 7 day rental and CPM otherwise known as a continuous passive motion for 30 days rental.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold therapy unit, 7 day rental:** 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

**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 Chapter, Continuous-flow cryotherapy.

**Decision rationale:** California MTUS/ACOEM Guidelines do not address cold therapy units. Therefore, Official Disability Guidelines has been referred to in this case. Under Official Disability Guidelines, a continuous flow cryotherapy unit is recommended as an option after surgery, but not for nonsurgical treatment. Furthermore, it states that postoperative use generally may be up to 7 days, including home use. However, as the patient is now 4 months postoperative, the medical necessity does not meet guideline criteria for the use of a cryotherapy unit. As such, the requested service is non-certified.

**CPM (Continuous Passive Motion) for 30 days, rental:** 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.

**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 Chapter, Continuous Passive Motion (CPM).

**Decision rationale:** The California MTUS/ACOEM Guidelines do not address the use of this equipment. Therefore, Official Disability Guidelines has been referred to in this case. Under Official Disability Guidelines, it states that for home use up to 17 days after surgery while patient is at risk of a stiff knee or immobile or unable to bear weight, under these conditions of low postoperative mobility or inability comply with rehabilitation exercises following a total knee arthroplasty or revision, this may include patients with complex regional pain syndrome, extensive arthrofibrosis or tendon fibrosis, or physical, mental, or behavioral inability to participate in active physical therapy. Because the patient is 4 months postoperative, she no longer meets the criteria for the use of a CPM device in the home. Furthermore, the patient has not been listed as unable to perform physical therapy or home health exercise programs. As such, the requested service does not meet guideline criteria and is non-certified.