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| Case Number: | CM13-0031423 | | |
| Date Assigned: | 12/04/2013 | Date of Injury: | 05/20/1992 |
| Decision Date: | 01/28/2014 | UR Denial Date: | 09/24/2013 |
| Priority: | Standard | Application Received: | 10/03/2013 |

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 and Rehabilitation, 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 59 year-old female sustained a knee injury on 5/20/92 after trying to break up a fight between two students while employed with the [REDACTED]. Per report of 10/19/12, diagnoses include Chronic lumbar/thoracic musculoligamentous sprain/strain and right Sacroiliitis. Treatment has included medications, rest, physical therapy, psychotherapy, acupuncture, sacroiliac (SI) Joint fusion, and bilateral knee meniscectomies with persistent right knee internal derangement. Open magnetic resonance imaging (MRI) of right knee with intra-articular contrast (MR Arthrogram) on 8/2/13 had findings of anterior and posterior cruciate ligaments are intact, no arthroscopically visible tear by MR arthrographic criteria, and patellofemoral joint reveals mild diffuse chondromalacic changes. She underwent a right arthroscopic knee surgery for a lateral meniscus tear on 9/12/13, as request by physician, per report of 9/16/13 for Retro Purchase of Cold Therapy Compression Unit, Cold Therapy Pad, and Cold Therapy Sterile Wrap. Requests were non-certified on 9/24/13. From the submitted reports, there is no documentation on how often the unit will be used, short-term or long-term goals of treatment with the Retrospective Purchase of Cold Therapy Compression unit nor is there any evidence to include change in work status, increased in activities of daily living (ADLs), decreased visual analogue scale (VAS) score, medication usage, or treatment utilization from treatment already rendered.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338.

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

Decision rationale: The MTUS Guidelines is silent on specific use of cold compression therapy, but does recommend standard cold pack for post exercise. The Official Disability Guidelines (ODG) specifically addresses the short-term benefit of cryotherapy post knee surgery; however, limits the use for 7-day post-operative period as efficacy has not been proven after. Given such, the Cold Therapy Unit is not medically necessary and appropriate.

Cold therapy pad: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338.

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

Decision rationale: Since the request for cold therapy unit is not medically necessary, none of the associated (including cold therapy pads) are medically necessary.

Cold therapy sterile wrap: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chapter Knee, Continuous-Flow Cryotherapy page 292

Decision rationale: Since the request for cold therapy unit is not medically necessary, none of the associated (including Cold therapy sterile wrap) is medically necessary.