

Case Number:	CM13-0041678		
Date Assigned:	12/20/2013	Date of Injury:	06/27/2008
Decision Date:	03/10/2014	UR Denial Date:	09/26/2013
Priority:	Standard	Application Received:	10/30/2013

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 Texas. 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 59-year-old male who reported an injury on 06/27/2008. The mechanism of injury was reported the patient was bending down into a case, stood and turned, and felt pain in his right knee. The patient was diagnosed with bilateral knee osteoarthritis and status post left total knee arthroplasty. The patient continued to complain of pain to the knee. The patient rated his pain at a 4/10 and 10 being the worst. The clinical documentation stated the patient had his right knee replaced on 04/26/2013. Objective findings of the knees revealed limited range of motion with flexion of 120 degrees on the right, 0 degrees on the left, extension was 0 degrees on the right and 90 degrees on the left, palpation of the medial joint and lateral joint line revealed tenderness bilaterally. Patellofemoral grind test was positive and healed incision was noted on the left knee. Treatment plan included physical therapy 2 times a week for 6 weeks for bilateral knees and medication to include Restoril and a motorized cooling unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of a motorized cold unit for the left knee: Upheld

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

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

Decision rationale: The requested motorized cold unit knee for purchase of the left knee is not medically necessary or appropriate. The Official Disability Guidelines (ODG) recommends the use of this type of unit for up to 7 days in the management of a patient's postsurgical pain. There is no indication within the submitted documentation that the patient has recently undergone any surgical procedures to the left knee. Additionally, the purchase of this type of unit would not be supported as this type of equipment is only recommended for up to a 7 day period. As such, the requested motorized cold unit for the knee for purchase for the left knee is not medically necessary or appropriate.