

Case Number:	CM13-0046528		
Date Assigned:	12/27/2013	Date of Injury:	06/04/2013
Decision Date:	07/30/2014	UR Denial Date:	10/23/2013
Priority:	Standard	Application Received:	10/31/2013

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 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 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:

The patient is a 55 year old male who was injured on 6/4/2013. He sustained an injury to his mid and lower back while performing his usual and customary duties. A progress report dated 9/9/13 indicates that the patient presented for an orthopedic evaluation. He continues to complain of knee locking and complains of recurrent swelling. Objective findings on exam revealed no evidence of joint effusion of the knee. His range of motion is from 0-115 degrees. He had tenderness over the lateral joint line. He was tender over the medial joint line to pressure. McMurray's produces pain laterally and he is able to extend against gravity. He was diagnosed with right knee meniscal tear with osteochondral defect. He was recommended for arthroscopy surgery for microfracturing and partial meniscectomy. During an office visit on 6/6/13, the patient was noted to have complaints of pain above the knee with swelling. On exam, he was noted to be tender to palpation at the pre-patellar region, distal, quad, popliteal region. Active range of motion revealed flexion on the right from 0-135 and on the left 0-103. Manual muscle testing was 5/5. He has positive pivot shift bilaterally. He has joint line tenderness. The assessment is of right knee pain/strain. Therapy is indicated and an electrical stimulation unit has been requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

PURCHASE OF A COLD THERAPY UNIT: Upheld

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

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

Decision rationale: The referenced guidelines state that a cold therapy unit is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. Although the patient qualifies for the cold therapy unit after surgery, purchase of the unit implies use for longer than the 7-day recommendation. Thus, the medical necessity for this request is not established.