

Case Number:	CM13-0049145		
Date Assigned:	12/27/2013	Date of Injury:	08/23/2012
Decision Date:	05/30/2014	UR Denial Date:	10/29/2013
Priority:	Standard	Application Received:	11/07/2013

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 Orthopedic Surgery 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 28-year-old female sustained an industrial injury on 8/23/12. The 11/19/12 left knee MRI revealed joint effusion. The 9/12/13 progress report cited persistent left knee pain with complaints of locking, popping, giving way, and swelling. Functional difficulty was documented in prolonged standing and walking. Physical exam findings showed pes anserine bursa swelling and tenderness, patellar tendon tenderness, range of motion 6-100 degrees, positive McMurray's sign, medial joint line tenderness with mild swelling, 4/5 flexion and extension strength, and no instability. The diagnosis was left knee internal derangement with pes anserine bursitis. Failure of reasonable conservative pharmacologic and non-pharmacologic treatment, including physical therapy and injections, was documented. The treatment plan recommended left knee arthroscopy with pes anserine bursectomy. A motorized cold therapy unit was prescribed for post-operative use. The 10/29/13 utilization review recommended partial certification of a cold therapy unit for 7 days rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

MOTORIZED COLD THERAPY UNIT FOR PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 1015-1017. Decision based on Non-MTUS Citation ODG, KNEE AND LEG CHAPTER (UPDATED 6/7/13), CONTINUOUS-FLOW CRYOTHERAPY.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) KNEE CHAPTER, CONTINUOUS FLOW CRYOTHERAPY.

Decision rationale: Under consideration is a request for a motorized cold therapy unit. The Official Disability Guidelines state that continuous flow cryotherapy may be recommended as an option for post-operative use, up to 7 days. The 10/29/13 utilization review recommended partial certification of the cold therapy unit for up to 7 days consistent with guidelines. There is no compelling reason to support the use of a cold therapy system beyond the 7 days rental previously approved. Therefore, this request for a motorized cold therapy unit for purchase is not medically necessary.