

<b>Case Number:</b>	CM14-0002001		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	03/16/2011
<b>Decision Date:</b>	06/20/2014	<b>UR Denial Date:</b>	12/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2014

### 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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 injured worker is a 26-year-old female who reported an injury of unknown mechanism on 03/16/2011. In the clinical note dated 10/31/2013, the injured worker complained of postoperative left knee arthroscopic pain. The left knee surgery was done on 08/08/2013. It was noted that the injured worker's pain level was rated an 8/10 and with constant pain irritated with walking. The physical examination of the left knee revealed flexion of 80 degrees with end range pain and tenderness along the lateral aspect of the knee. The diagnoses included status post left knee arthroscopic surgery and stress deferred. The treatment plan included the injured worker to remain on temporarily total disability until 12/12/2013 and to begin a course of home stretches and home exercises on a daily basis. The injured worker was to be re-evaluated in 30 days. The Request for Authorization was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Q-TECH COLD THERAPY UNIT 35 DAY RENTAL WITH PURCHASE OF UNIVERSAL COLD WRAP AND 1/2 LEG COMPRESSION WRAP (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 Official Disability Guidelines (ODG) Knee, Continuous-flow cryotherapy.

**Decision rationale:** The request for Q-Tech cold therapy unit 35 day rental with purchase of universal cold wrap and ½ leg compression wrap (left knee) is non-certified. The Official Disability Guidelines (ODG) state that cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. In the clinical notes provided for review, there was a lack of documentation of the injured worker physician requesting cryotherapy. Furthermore, the guidelines state that cryotherapy is recommended as an option up to 7 days to be included in home use after surgery. The request for cold therapy is in excess by requesting a 35 day rental over the recommended 7 days. Therefore, the request for Q-Tech cold therapy unit 35 day rental with purchase of universal cold wrap and ½ leg compression wrap (left knee) is non-certified.