

Case Number:	CM14-0020397		
Date Assigned:	04/25/2014	Date of Injury:	04/16/2008
Decision Date:	07/07/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	02/18/2014

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 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:

The claimant is a 48-year-old gentleman who injured his left knee on April 16, 2008. The records provided for review indicate that following a course of conservative care the claimant underwent an arthroscopic medial meniscectomy on August 30, 2013. The specific requests in this case are for the postoperative use of a Q-Tech cryotherapy device on a twenty-one day rental, a half leg wrap for use with the cryotherapy device, a universal therapy wrap, a CPM machine and a postoperative pain pump.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO: Q-TECH COLD THERAPY UNIT, 21 DAY RENTAL; 8/31/13: 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): 337-339.

Decision rationale: Based on California ACOEM Guidelines and supported by the Official Disability Guidelines, the request for twenty-one day rental of a cryotherapy device retrospective to August 31, 2013 would not be indicated. ACOEM Guidelines recommend the local application of cold therapy. The Official Disability Guidelines recommend the use of

cryotherapy for no more than seven days in the postoperative setting. Therefore, the specific request for twenty-one day rental of the cold therapy device would not be indicated.

UNIVERSAL THERAPY WRAP: 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 ODG, Treatment In Worker's Comp, 18th Edition, 2013 Updates: Forearm/Wrist/Hand Procedure - Vasopneumatic Devices.

Decision rationale: California ACOEM and MTUS Guidelines do not address this request. When looking at Official Disability Guidelines, a therapy wrap for vasocompressive purposes would not be supported. Given the nature of the claimant's surgery and initial weight bearing status, the need of a compressive garment following a knee arthroscopy and meniscectomy is not indicated. The specific request for a universal therapy wrap would not be supported.

RETRO: KNEE CPM UNIT WITH PADS, 30 DAY RENTAL; 8/31/13: 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 ODG, Treatment In Worker's Comp, 18th Edition, 2013 Updates: Continuous Passive Motion (CPM).

Decision rationale: The California MTUS and ACOEM Guidelines do not address this request. When looking at Official Disability Guidelines, a continuous passive motion machine would not be indicated. Records indicate this individual underwent a surgical arthroscopy with partial medial meniscectomy. The Official Disability Guidelines do not support the use of a CPM following a simple arthroscopy meniscectomy procedure. The nature of the claimant's surgery would not justify the use of this device.

RETRO:ON Q PAIN PUMP, PURCHASE; 8/30/13: 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 ODG, Treatment In Worker's Comp, 18th Edition, 2013 Updates: Shoulder Procedure - Postoperative Pain Pump.

Decision rationale: California MTUS and ACOEM Guidelines do not address the use of pain pumps. Based on the Official Disability Guidelines, the use of postoperative pain pumps is not supported as randomized clinical trials do not support the efficacy or long term benefit of a pain

pump in the postsurgical setting. The request in this case would not be indicated as medically necessary.