

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0061749 | | |
| Date Assigned: | 07/09/2014 | Date of Injury: | 04/12/2010 |
| Decision Date: | 09/16/2014 | UR Denial Date: | 04/15/2014 |
| Priority: | Standard | Application Received: | 05/02/2014 |

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 Anesthesiology and Pain Medicine, and is licensed to practice in Florida. 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 47-year-old male with a reported date of injury on 04/12/2010; the mechanism of injury was a fall. The injured worker was diagnosed with status post left thumb tuft fracture and proximal phalanx fracture, right knee meniscal tear status post to arthroscopic debridement surgeries, right lower extremity complex regional pain syndrome/reflex sympathetic dystrophy, left knee sprain/strain with MRI evidence of complex medial meniscus tear, lumbosacral spine strain/sprain with lumbar spondylosis and right lower extremity radicular pain; stress, anxiety, and depression. Prior treatments included psychiatric treatment, lumbar sympathetic blocks, a lumbar medial branch block, and chiropractic treatment. Diagnostic studies included electromyography of the upper extremities on 12/23/2010; electrodiagnostic studies of the upper extremities on 01/09/2011; an MRI of the right knee on 01/24/2011; an MRI of the lumbar spine on 05/16/2011; an MRI of the left knee on 04/10/2012, and a CT of the abdomen and pelvis on 09/24/2013. The clinical note dated 03/26/2014 noted the injured worker reported improvement in pain with the use of Norco in place of tramadol. The injured worker continued to be symptomatic with severe bilateral knee pain. The physician indicated the injured worker was awaiting possible left knee surgery. The injured worker reported burning, sharp, and stabbing pain to the right knee with complaints of aggravation of pain with walking. The injured worker had swelling and discoloration to the right knee. The injured worker rated his pain at 7/10 with use of medication and 10/10 without medication. The injured worker indicated he had a 30% improvement in pain and a 30% improvement in function with his current medication; and he had improved ability to ambulate and participate in activities of daily living with his medication. The injured worker had 3/5 motor strength in all major muscle groups to the right lower extremity, as compared to the left. The right knee appeared mottled and shiny in appearance, and infrared surface temperature testing revealed a 2-degree temperature differential

with the right knee average temperature of 93.2 degrees, and the left knee at 95.4 degrees. The injured worker had 2+ pitting edema in the right leg, as well as allodynia to light touch. The injured worker had a significant loss of range of motion to the left knee, with tenderness to palpation over the joint line. The injured worker's medication regimen included Norco, gabapentin, omeprazole, and trazodone. The physician's treatment plan included recommendations for continuation of medications, a lumbar sympathetic block, and arthroscopic left knee surgery. The physician's rationale for the request was not indicated in the medical records. The Request for Authorization was not provided within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME - Cold Therapy Unit Rental x 10 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345. Decision based on Non-MTUS Citation Official Disability Guidelines -Knee And Leg (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & leg, Continuous-flow cryotherapy.

Decision rationale: The request for DME - cold therapy unit rental x 10 days is not medically necessary. The California MTUS/ACOEM guidelines state at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist are. The Official Disability Guidelines note, continuous flow 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 (e.g., muscle strains and contusions) has not been fully evaluated. Within the provided documentation, the physician indicated the injured worker is awaiting approval of a left knee arthroscopic surgery. However, there is a lack of documentation indicating the injured worker has been approved for the surgery, and it has been scheduled for a date within the near future. The requesting physician's rationale for the requested cold therapy unit rental for 10 days is not indicated. The request for use of the unit for 10 days would exceed the guideline recommendations, as the guidelines recommend postoperative use for 7 days. Additionally, the submitted request does not indicate the site at which the unit is to be applied. As such, the request for DME - cold therapy unit rental x 10 days is not necessary.