

Case Number:	CM14-0070243		
Date Assigned:	07/14/2014	Date of Injury:	09/10/2013
Decision Date:	10/14/2014	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	05/15/2014

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 Family Medicine 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 is a 35-year-old male patient who reported an industrial injury on 9/10/2013, one year ago, to the left knee, left hip, left wrist and face, attributed to the performance of his usual and customary job duties reported as having the forks on a forklift become stuck and fall onto the patient once they were loosened knocking him to the ground. The patient complained of left knee pain with swelling, laceration to the left wrist, abrasion to the lip, along with lower back and hip pain. The patient was diagnosed with s/p left knee contusion/laceration/sprain with bone marrow edema within the patella, anterior lateral aspect of the lateral femoral condyle with abnormal signal involving the quadriceps tendon; abnormal signal within the posterior horn and body junction of the medial meniscus; status post left wrist laceration; de Quervain's tenosynovitis; lumbar musculoligamentous sprain/strain; and history of lacerated lip. The patient was treated with medications; chiropractic care; physical therapy; electric muscle stimulation. The patient was subsequently recommended to have outpatient arthroscopic left partial medial meniscectomy chondroplasty and debridement with 12 sessions of postoperative PT. The patient is noted to be eight months status post arthroscopy to the left knee with continued symptoms and giving away.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Care Cold Therapy Unit (5 of 5), 2 units (2 weeks): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Knee & Leg Procedure Summary

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg chapter--arthroscopy; meniscectomy; Low back chapter--Cold/heat packs

Decision rationale: The use of the cold circulation units are recommended by evidence-based guidelines for hospital use but not for home use. There is no demonstrated medical necessity for this cold therapy unit with appliance to be provided to the patient subsequent to the surgical intervention to the knee for home treatment as opposed to the conventional treatment with cold packs. The medical necessity of the DME for the home treatment of the patient was not supported with objective evidence to support medical necessity. There is no objective evidence to support the home use of the requested cold therapy system as opposed to the customary RICE for the treatment of pain and inflammation after the initially recommended seven days of home therapy with a cold therapy unit. There was no clinical documentation provided to support the medical necessity of the requested DME in excess of the recommendations of the California MTUS. The use of a cold circulation pump post operatively is recommended for up to seven (7) days and not recommended for longer durations of time. The cold therapy units are not medically necessary for the treatment of the knee post operatively as alternatives for the delivery of heat and cold to the knee are readily available. The request for authorization of the cold therapy by name brand is not supported with objective medically based evidence to support medical necessity. There is no provided objective evidence to support the medical necessity of the compression as opposed to the more conventional methods for the delivery of cold for the cited surgical intervention rehabilitation. The CA MTUS; the ACOEM Guidelines, and the ODG recommend hot or cold packs for the application of therapeutic cold or heat. The use of hot or cold is not generally considered body part specific. The Official Disability Guidelines chapter on the knee and lower back states a good example of general use for hot or cold. The issue related to the request for authorization is whether an elaborate mechanical compression device is necessary as opposed to the recommended hot or cold pack. There is no demonstrated medical necessity for the requested cold unit for the treatment of the postoperative knee.