MAXIMUS Federal Services

| Case Number: | CM14-0186729 | | |
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| Date Assigned: | 11/14/2014 | Date of Injury: | 03/17/2014 |
| Decision Date: | 01/05/2015 | UR Denial Date: | 10/17/2014 |
| Priority: | Standard | Application Received: | 11/10/2014 |

## 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 Emergency Medicine and is licensed to practice in Texas. 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 48-year-old female who reported an injury on 03/17/2014 due to an unspecified mechanism of injury. On 10/08/2014, the injured worker complained of left hip pain rated at 7/10 and left knee pain rated at 5/10. The physical examination revealed tenderness to palpation of the thigh and upper hip on the right. Range of motion of the thigh and hip was documented as 90 degrees on flexion, 10 degrees on extension, 25 degrees on abduction, 15 degrees on adduction, 20 degrees on internal rotation, and 30 degrees on external rotation. An examination of the knee showed range of motion was documented as 90 degrees of flexion on the left and 130 degrees of flexion on the right. He had a positive Apley's grinding test on the right and negative on the left. An examination of the ankle and foot showed range of motion was 10 degrees on rotation, 20 degrees of flexion, 10 degrees on extension, 20 degrees on inversion, and 10 degrees on eversion on the right. Her past treatments included physical therapy and medication. Her medications included Ultracet 325/37.5 mg, Naprosyn sodium 550 mg, Flexeril 7.5 mg, and Prilosec 20 mg. Documentation regarding pertinent diagnostics and surgical history was not provided for review. The treatment plan included a purchase for crutches, the purchase of a half leg wrap, then purchase of a universal therapy wrap, and a rental of a [redacted] cold therapy recovery system with wrap. The rationale for treatment was not provided. The Request for Authorization form was not submitted for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Crutches for purchase:** 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 and Leg, Walking aids (canes, crutches, braces, orthoses, & walkers).

**Decision rationale:** According to the Official Disability Guidelines, crutches may be recommended as a walking aid for those with a disability, pain, and age related impairments. The injured worker was noted to be status post left knee arthroscopy performed on an unspecified date. However, the documentation failed to indicate a clear rationale for the medical necessity of crutches. Although, the injured worker was noted to be status post left knee surgery, the date of the surgery was not specified. As the date of the surgery was not specified, the request is not supported by the guidelines. Therefore the request is not medically necessary.

**Half Leg Wrap for purchase:** 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 and Leg, Durable medical equipment (DME).

**Decision rationale:** According to the Official Disability Guidelines, it may be recommended if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment, to include the ability to withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person with absence of illness or injury, and is appropriate for use in the patient's home. The injured worker was noted to be status post left knee arthroscopy. However, the date of surgery was not noted without this information the request is not supported by the guidelines. In addition, the medical necessity of a half leg wrap was not stated. As such, the request for Half Leg Wrap for purchase is not medically necessary.

**Universal Therapy Wrap for purchase:** 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, Durable Medical Equipment (DME).

**Decision rationale:** According to the Official Disability Guidelines, it may be recommended if there is a medical need and if the device or system meets Medicare's definition of durable

medical equipment, to include the ability to withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person with absence of illness or injury, and is appropriate for use in the patient's home. The injured worker was noted to be status post left knee arthroscopy. However, the date of surgery was not noted without this information the request is not supported by the guidelines. In addition, the medical necessity of a half leg wrap was not stated. As such, the request for universal therapy wrap for purchase is not medically necessary.

[redacted] **Cold Therapy Recovery System with wrap for rental:** 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 MTUS Official Disability Guidelines (ODG), Knee and Leg, Continuous-Flow Cryotherapy.

**Decision rationale:** According to the Official Disability Guidelines, continuous flow cryotherapy may be recommended as an option postoperatively within 7 days to include home use. The injured worker was noted to have a left knee arthroscopy. However, there was a lack of documentation to indicate when the surgery took place. Without this information the request would not be supported as cryotherapy is only recommended up to 7 days postop. In addition, the request failed to provide the duration for the cryotherapy unit. Given the above, the request for [redacted] Cold Therapy Recovery System with wrap for rental is not medically necessary.