

<b>Case Number:</b>	CM14-0202873		
<b>Date Assigned:</b>	12/15/2014	<b>Date of Injury:</b>	12/26/2010
<b>Decision Date:</b>	08/14/2015	<b>UR Denial Date:</b>	11/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/04/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 injured worker is a 48-year-old male who sustained an industrial injury on 12/26/10. Injury occurred when he was transporting a broiler weighing approximately 50 pounds that fell, striking him in the left knee and foot. He underwent left knee arthroscopy with debridement, partial medial meniscectomy, and chondroplasty of the medial tibial plateau on 10/17/11, repeat left knee arthroscopy with partial meniscectomy and chondroplasty on 10/20/12, and left partial knee replacement (medial compartment) on 9/25/13. The 10/6/14 initial orthopedic report cited constant grade 8/10 left knee pain radiating down to the left foot with tingling. He reported left knee swelling. Pain was increased with prolonged standing, walking, and while performing exercise. Lower extremity knee exam documented antalgic gait with hinged knee brace. There was tenderness to palpation over the medial joint line, patella pain with pressure, patellofemoral grinding noted, and no instability. Clark's test was positive. Range of motion was limited to -5 to 115 degrees on the left. The diagnosis included traumatic internal derangement of the knee with multiple surgeries. He had recurrent pain and loss of full extension, pain in the medial joint compartment, and possible loose bodies in the knee. The treatment plan recommended left knee arthroscopy examination and removal of loose bodies. Associated surgical requests included the purchase of a cold therapy unit and crutches for left knee surgery. The 11/3/14 utilization review documented that the request for left knee diagnostic arthroscopy was medically necessary. The request for purchase of a cold therapy unit was modified to rental of a cold therapy unit for 7 days. The request for crutches was found to be medically necessary.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated Surgical Service: Purchase Cold Therapy Unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**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, Continuous flow cryotherapy.

**Decision rationale:** The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous-flow cryotherapy is an option for up to 7 days in the post-operative setting following knee surgery. The 11/3/14 utilization review decision modification of the request for purchase of a cold therapy unit to 7-day rental. There is no compelling reason in the records reviewed to support the medical necessity of a cold therapy unit beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.

**Associated Surgical Service: Crutches: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Walking aids (canes, crutches, braces, orthoses, & walkers).

**Decision rationale:** The California MTUS guidelines support the use of crutches for partial weight bearing for patients with knee complaints. The Official Disability Guidelines state that disability, pain, and age-related impairments determine the need for a walking aid. Assistive devices can reduce pain and allow for functional mobility. The post-operative use of crutches is consistent with guidelines. Therefore, this request is medically necessary.