

<b>Case Number:</b>	CM14-0207013		
<b>Date Assigned:</b>	12/19/2014	<b>Date of Injury:</b>	05/08/2013
<b>Decision Date:</b>	02/17/2015	<b>UR Denial Date:</b>	11/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/10/2014

### 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 Orthopedic Surgery, has a subspecialty in Sports 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:

The injured worker is a 65-year-old female who reported an injury on 05/08/2013. The mechanism of injury was not provided within the submitted documentation for review. Her diagnoses include cervical spine strain with radicular complaints, left shoulder strain with impingement, left wrist pain, left wrist strain, lumbar strain with radicular complaints, and right knee strain. Her past treatments included medications. Per clinical note dated 10/20/2014, diagnostic studies include a left shoulder MRI and a lumbar MRI performed on 11/27/2013. The clinical note also indicates there was an EMG/NCV of the bilateral lower extremities performed on 05/21/2014, and a right knee MRI performed on 09/09/2014. Her surgical history was noncontributory. The injured worker presented on 10/20/2014 with complaints of left shoulder pain that had improved with medication. The injured worker also complained of right knee pain when she would hold her knee in a fixed position for over 30 minutes, rated a 3/10 to 8/10. She also stated that there was popping and clicking in her right ankle. Upon physical examination, it was noted that the injured worker ambulated with an antalgic gait. Upon physical examination of the right knee, tenderness to palpation was noted about the lateral joint line. There was medial effusion and crepitus as well. Range of motion was limited from 0 to 120 degrees. A positive McMurray's test was noted. Negative anterior/posterior drawers and Lachman test were noted. A negative valgus and varus stress/laxity test was noted. Her current medication regimen was not noted in the documentation submitted for review. The treatment plan included a re-request for authorization for a right knee arthroscopy, medial and lateral meniscectomy and chondroplasty as needed. Authorization was also requested for the patient to proceed with a course of postoperative physical therapy twice a week for 4 weeks to improve range of motion of the right knee. In addition, a Request for Authorization for the patient to be provided with a cold therapy unit for 3 weeks postoperation, and a return in 4 weeks for further re-evaluation. The

rationale for the request was not provided. A Request for Authorization form was not submitted in the documentation for review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Post op cold therapy unit right knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg, Continuous Flow Cryotherapy

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), Continuous-flow cryotherapy.

**Decision rationale:** The request for post op cold therapy unit right knee is not medically necessary. The patient has right knee pain. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery, but not for nonsurgical treatment. The documentation submitted for review provides evidence that a right knee arthroscopy with medial and lateral meniscectomy and chondroplasty was requested. The Guidelines recommend up to 7 days post-operative use, including home use. However, the request did not indicate the number of days the unit was being requested for. In the absence of the aforementioned documentation, the request does not support the evidence based guidelines. As such, Post op cold therapy unit right knee is not medically necessary.