

<b>Case Number:</b>	CM14-0041870		
<b>Date Assigned:</b>	06/30/2014	<b>Date of Injury:</b>	07/24/2011
<b>Decision Date:</b>	02/19/2015	<b>UR Denial Date:</b>	03/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2014

### **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: California  
Certification(s)/Specialty: Physical Medicine & Rehabil

### **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 patient is a 67-year-old male with date of injury of 07/24/2011. According to progress report dated 12/17/2013, the patient is status post right total knee arthroplasty on 12/14/2013. The treating physician states that the patient requires a skilled nursing at home for 10 days as he lives in a 2-story apartment and does not have anyone to take care of him at home. According to progress report dated 10/02/2013, the patient presents with low back, right knee, and left knee pain. It was noted the patient presents with a right knee brace. Examination revealed "right anterior thigh intact, right lateral calf intact, right lateral (illegible)." According to AME report dated 10/03/2013, the patient continues with right knee pain notably in the anterior and posterior aspect of the right knee. There was giving-way of the knee noted. The pain is temporarily relieved with medications. Progress report dated 09/03/2013 notes the patient complains with right knee pain. Examination of the right knee revealed tenderness present in the medial and lateral aspect. Swelling and effusion were present in the right knee. Range of motion was noted as extension 170 degrees on the right and 120 degrees on the left. Strength test on the right is flexion 4/5 and flexor 4/5. There is positive patella grind maneuver and popliteal cyst present in the right. Hamstring tenderness was noted. The listed diagnoses are: 1. Right knee severe tricompartmental arthritis. 2. Lumbar spine degenerative disk disease at L3-L4. 3. Lumbar spine facet syndrome at L5-S1. 4. Bilateral knee degenerative arthrosis.

This patient is status post right knee arthroplasty on 12/14/2013. This is request for Universal Therapy Wrap, half-leg garment, Q-Tech cold therapy rental, and a front-wheeled walker for purchase. The utilization review denied the request on 03/17/2014. The medical file provides progress reports from 09/03/2013 through 01/09/2014 which provide no discussion regarding the request.

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

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

#### **Universal therapy wrap for purchase: Overturned**

**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 (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines; Knee Chapter, Hot/Cold Therapy

**Decision rationale:** This patient is status post right knee arthroplasty on 12/14/2013. The current request is for Universal Therapy Wrap for purchase. Universal therapy wraps are reusable therapy Gel pack which can be applied either hot or cold. The ACOEM Guidelines 300 states, "At-home local applications of heat or cold are as effective as those performed by therapists." The ODG guidelines under its knee chapter considers cold/heat therapy as a recommended option. ACOEM and ODG recommends this modality as an option. This request is medically necessary.

#### **Half leg garment for purchase: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & 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 Chapter, Continuous-Flow Cryotherapy

**Decision rationale:** This patient is status post right knee surgery on 12/14/2013. The current request is for half-leg garment for purchase. The ODG Guidelines, knee chapter has the following regarding continuous-flow cryotherapy: "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 use." In this case, the leg garment is intended to facilitate delivery of the cold therapy unit. Given the patient has not met the indication for a cold therapy unit, the requested half-leg garment is not medically necessary.

#### **Q-Tech Cold Therapy for rental: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & 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 Chapter, Continuous-Flow Cryotherapy

**Decision rationale:** This patient is status post right knee arthroplasty on 12/14/2013. The current request is for Q Tech cold therapy for rental. The medical file provided for review does not include any discussion regarding this request. The ODG Guidelines, knee chapter has the following regarding continuous-flow cryotherapy: "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 use." The MTUS Guideline recommends the duration of post-operative use of continuous-flow cryotherapy to be 7 days. In this case, there are no discussions on the duration of use, and the cold therapy unit outside of the postoperative 7 days is not medically necessary.

**Front wheel walker for purchase:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Knee & leg, Walking Aids (Canes, Crutches, Braces, Orthoses & Walkers)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Knee Chapter, Walking Aids

**Decision rationale:** The ACOEM and MTUS do not discuss front wheeled walkers. ODG does provide a discussion on walking aids under the knee chapter. ODG states, walking aids are "recommended, as indicated below. Almost half of patients with knee pain possess a walking aid. Disability, pain and age-related impairment seem to determine the need for a walking aid. Non-use is associated with less need, negative outcome, and negative evaluation of the walking aid." In this case, the patient is status post right knee surgery and the requested walker to alleviate weight bearing and to assist the patient with ambulation is reasonable and supported by ODG guidelines. The request is medically necessary.