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| Case Number: | CM15-0003397 | | |
| Date Assigned: | 01/14/2015 | Date of Injury: | 02/28/2009 |
| Decision Date: | 04/14/2015 | UR Denial Date: | 12/31/2014 |
| Priority: | Standard | Application Received: | 01/07/2015 |

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, Indiana, New York
Certification(s)/Specialty: Internal Medicine

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 53 year old male who sustained an industrial injury on February 28, 2009. He has reported pain of the right knee, right hip, and low back and has been diagnosed with herniated nucleus pulposus L4-5 right and low back pain syndrome. Treatment has included medications, referral for epidural steroid injection, and physical therapy. Currently the injured worker has tenderness of the paraspinal right, trigger point located right S1 region. The treatment plan included a spinal consultation, epidural injection, and MRI.

IMR ISSUES, DECISIONS AND RATIONALES

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

Kodiak Combo Unit to Right Knee: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Continuous cryotherapy unit.

Decision rationale: Pursuant to the Official Disability Guidelines, Kodiak combination unit to right knee (continuous flow cryotherapy) is not medically necessary. Continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use maybe for up to seven days, including home use. In the post operative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling and narcotic use; however the effect on more frequently treated acute injuries has not been fully evaluated. In this case, the injured worker's working diagnoses are chondromalacia; enthesopathy of the hip; sprained foot; low back syndrome; effusion right knee; right knee pain; trochanteric tendinitis right hip; arthritis of the right knee; and low back pain. A progress note dated October 14, 2014 shows the treating physician requested arthroscopy for major debridement and synovectomy. There was no request, indication or clinical rationale for a Kodiak combination unit. Follow-up progress note from December 18, 2014 discussed spine surgery. There was no discussion of the DME (Kodiak combination unit). There was discussion of a spine consultation, MRI lumbar spine and an epidural steroid injection. Consequently, absent clinical documentation with the request for DME (Kodiak combination unit), and a clinical indication and rationale for DME, Kodiak combination unit to right knee (continuous flow cryotherapy) is not medically necessary.