

<b>Case Number:</b>	CM15-0104897		
<b>Date Assigned:</b>	06/09/2015	<b>Date of Injury:</b>	01/30/2015
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### 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: North Carolina

Certification(s)/Specialty: Family Practice

### 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 67 year old male, who sustained an industrial injury on January 30, 2015. He reported stepping down from a step stool, off balanced, and all the weight went on the right side feeling pain in the right knee. The injured worker was diagnosed as having severe tricompartmental right knee osteoarthritis. Treatment to date has included x-rays, cortisone injection, bracing, physical therapy, and medication. Currently, the injured worker complains of right knee pain. The Initial Orthopaedic Surgery Consultation dated April 30, 2015, noted the injured worker reported a steroid injection to the right knee only lasted 2-3 weeks. The injured worker was noted to be unable to walk or stand for more than five minutes at a time because of the pain. Examination of the knees was noted to show small effusion in the right knee, severe varus deformities, positive crepitus and joint line tenderness medially bilaterally, and positive patellar grind on the right. Right knee x-rays were noted to show severe tricompartmental osteoarthritis with bone-on-bone changes over the medial compartment, multiple osteophytes, and severe joint narrowing over the patellofemoral joint. The treatment plan was noted to include requests for authorization for a right total knee replacement, with medical clearance, pre-operative lab work, a walker, cryo, post-op home physical therapy, home health care, post-op brace, CPM, and a cold therapy unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase cold therapy unit post operative right knee: 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), cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, cryotherapy.

**Decision rationale:** The California MTUS and the ACOEM do not specifically address the requested service. The ACOEM does recommend the at home local application of cold packs the first few days after injury and thereafter the application of heat packs. The Official Disability Guidelines section on cryotherapy states: Recommended as an option after surgery but not for nonsurgical treatment. The request is for post-surgical use however the time limit for request is not defined. Per the ODG, cold therapy is only recommended for 7 days post operatively. Without the request specifying the amount of time the unit will be used post operatively, the request cannot be certified.