

<b>Case Number:</b>	CM15-0032630		
<b>Date Assigned:</b>	02/26/2015	<b>Date of Injury:</b>	12/29/2013
<b>Decision Date:</b>	04/09/2015	<b>UR Denial Date:</b>	01/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/20/2015

### 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  
 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:

The injured worker (IW) is a 57-year-old male who sustained an industrial injury on 12/29/2013. He has reported pain in the right knee. Diagnoses include internal derangement of the right knee, rotator cuff tendinosis of the right shoulder, herniated nucleus pulposus of the lumbar spine with radiculopathy, and sprain/strain of right ankle. Treatments to date include medication, use of a stationary bike, and home therapy. A progress note from the treating provider dated 12/29/2014 indicates the IW was having right knee pain that he rated as a 7-8/10. The worker was limited in the distance he could tolerate walking. He also had right shoulder, right ankle, and low back complaints. Examination noted tenderness over the medial joint line, a positive McMurray's sign on the right, and decreased range of motion. Prior to this exam, the IW has had approximately 10 sessions of physical therapy that did not help. The treatment plan was for a right knee arthroscopy and meniscetomy, pre-op EKG, Labs, and chest x-ray, venapro pneumatic compression device, crutches, a home therapy kit, a micro cool unit -4 weeks, and a M Pred Kit. On 01/23/2015 Utilization Review non-certified a request for a M-Pred Kit. Non-MTUS guidelines <http://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setId=dec92845-e713-42a3-83a7-3a46920b7eed> On 01/23/2015, Utilization Review modified a request for Micro cool unit - 4-week rental to Micro cool unit x7 day rental. The MTUS-ACOEM Guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Micro cool unit - 4-week rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG Knee Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline, Knee and Leg, Continuous flow cryotherapy.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of cryotherapy. According to ODG, Knee and Leg Chapter regarding continuous flow cryotherapy it is a recommended option after surgery but not for nonsurgical treatment. It is recommended for upwards of 7 days postoperatively. In this case, the request of 30 days exceeds the guideline recommendation. Therefore, the determination is for non-certification.

**M-Pred Kit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setId=dec92845-e713-42a3-83a7-3a46920b7eed>.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46 & 47.

**Decision rationale:** CA MTUS/Chronic Pain Medical Treatment Guidelines, Exercise page 46 and 47 state the exercise is recommended. "There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen." As the guidelines do not recommend any particular exercise program, there is lack of medical necessity for a M-Pred kit. Therefore, determination is for non-certification.