

<b>Case Number:</b>	CM15-0036217		
<b>Date Assigned:</b>	03/04/2015	<b>Date of Injury:</b>	05/13/2014
<b>Decision Date:</b>	04/13/2015	<b>UR Denial Date:</b>	01/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/26/2015

### 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: Physical Medicine & Rehabilitation

### 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 30-year-old female who reported an injury on 05/13/2014. The mechanism of injury involved repetitive activity. The current diagnoses include sciatica, internal derangement of the right knee with meniscal tear, musculoligamentous sprain/strain of the bilateral ankles, and left knee compensatory pain. The injured worker presented, on 11/07/2014, for an orthopedic consultation. It was noted that the injured worker underwent a course of physical therapy for the low back and right knee, which failed to provide a relief of symptoms. The injured worker presented with complaints of ongoing low back pain with radiating symptoms into the bilateral lower extremities, as well as bilateral knee pain and instability. Upon examination of the bilateral knees, there was moderate effusion of the right knee, positive patellofemoral grind test on the right, 150 degree flexion, 0 degree extension, positive medial joint line tenderness on the right and negative instability. There was 4/5 motor weakness on the right with diminished Achilles reflex. X-rays of the bilateral knees, obtained in the office, revealed normal findings. Recommendations at that time included a right knee arthroscopic surgery. There was no Request for Authorization form submitted 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 for 30 days: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): Table 13-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 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 Chapter, Continuous flow cryotherapy.

**Decision rationale:** The Official Disability Guidelines recommend continuous flow cryotherapy for up to 7 days following surgery. The current request for a 30 day rental of a postoperative cold therapy unit exceeds guideline recommendations. There were no exceptional factors noted. Given the above, the request is not medically appropriate.