

<b>Case Number:</b>	CM14-0123316		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	04/22/2014
<b>Decision Date:</b>	10/23/2014	<b>UR Denial Date:</b>	07/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/05/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 61-year-old male with a reported injury on 04/22/2014. The mechanism of injury was a slip and fall off stairs. The injured worker's diagnoses included a complex tear anterolaterally of the right lateral meniscus; patellofemoral disease with grade 3 chondromalacia involving more of the medial facet, right knee; synovitis of the right knee; and restricted and painful range of motion to the right knee. The injured worker's past treatments included ice and crutches. The injured worker's diagnostic testing included an x-ray of the right knee on 04/24/2014, which was negative for fracture injury, negative for joint misalignment, the suprapatellar bursa showed a small effusion, which in the clinical setting of trauma might indicate acute internal injury, and an MRI was recommended. The injured worker did have an MRI on 05/13/2014, which showed a horizontal tear involving a degenerated anterior horn lateral meniscus extending into the anterior root attachment, mild joint effusion suggesting post-traumatic synovitis; the intrinsic ligaments of the knee were intact, and there was no osseous contusion or cortical fracture. The injured worker's surgical history included a right knee arthroscopy with lateral meniscectomy, chondroplasty, lateral release, and synovectomy on 06/06/2014. The injured worker was evaluated presurgically on 06/06/2014. No documentation of postsurgical visits was provided for review. No medication list was provided. The request is for motorized cold therapy unit with pad (purchase), interferential unit with supplies (purchase), electrodes x18 pairs (purchase), and sterile electrodes x2 (purchase). The rationale for the request is for the treatment of a tear of the lateral cartilage or meniscus of the knee, chondromalacia of the patella, tenosynovitis and synovitis, and pain in the lower leg joint. The Request for Authorization form was submitted on 07/02/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Motorized Cold Therapy Unit with pad purchase: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES

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

**Decision rationale:** The request for Motorized Cold Therapy Unit with pad purchase is not medically necessary. The injured worker had a right knee arthroscopy on 06/06/2014. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery. Postoperative use generally may be up to 7 days, including home use. The Request for Authorization form was submitted on 07/02/2014, which was almost a month post-surgery. Additionally, given the short term recommended use, a rental of the machine would be appropriate. Therefore, the request for Motorized Cold Therapy Unit with pad purchase is not medically necessary.

**Interferential Unit with supplies - purchase: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION (ICS).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Interferential current therapy (IFC)

**Decision rationale:** The request for Interferential Unit with supplies - purchase is not medically necessary. The injured worker is status post right knee arthroscopy on 06/06/2014. The Official Disability Guidelines state that interferential current therapy is under study for osteoarthritis and recovery post knee surgery. After knee surgery, home interferential current therapy may help reduce pain, pain medication taking, and swelling while increasing range of motion, resulting in quicker return to activities of daily living and athletic activities. There is no recommendation by the Official Disability Guidelines. There was no postsurgical documentation provided for review. Additionally, the body part or parts for which this interferential unit was to have been applied was not specified, nor were there any parameters for frequency of stimulation, pulse duration, treatment time, or electrode placement. Therefore, the request for Interferential Unit with supplies - purchase is not medically necessary.

**Electrodes x 18 pairs - purchase: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested treatment/service is not supported by the documentation, the requested ancillary service is also not supported.

**Sterile Electrodes x 2 - purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested treatment/service is not supported by the documentation, the requested ancillary service is also not supported.