

Case Number:	CM14-0138770		
Date Assigned:	09/05/2014	Date of Injury:	11/01/2011
Decision Date:	10/16/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	08/27/2014

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 Nevada. 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 records presented for review indicate that this 42 year-old male was reportedly injured on 11/1/2011. The mechanism of injury is noted as a twisting injury. The most recent progress note, dated 8/11/2014, indicates that there were ongoing complaints of low back pain that radiates in the bilateral lower extremities, and right knee pain. The physical examination demonstrated right knee: positive tenderness to palpation patellofemoral joint, medial and lateral joint line. Positive crepitus. Positive effusion. Diagnostic imaging studies include an MRI of the right knee, dated 4/22/2014, which revealed moderate chondromalacia patella. Previous treatment includes physical therapy, knee brace, medications, and injections. A request had been made for cold therapy unit, and was not certified in the pre-authorization process on 8/19/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

COLD THERAPY UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES 11th edition 2013 knee and leg

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines ODG -TWC/ODG

Integrated Treatment/Disability Duration Guidelines; Shoulder (Acute & Chronic) - Continuous Flow Cryotherapy (updated 7/29/14)

Decision rationale: ODG guidelines recommend cold therapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. After review the medical records provided the claimant has right knee pain and treating physician has recommended arthroscopy. However, surgical procedure has not been approved at this point in time. Therefore, the need for cryotherapy is deemed not medically necessary.