

<b>Case Number:</b>	CM14-0172815		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	06/06/2008
<b>Decision Date:</b>	12/03/2014	<b>UR Denial Date:</b>	10/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2014

### 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 Family Medicine, 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:

This is a 55-year-old male patient who reported an industrial injury on 6/6/2008, over six (6) years ago, attributed to the performance of his usual and customary job tasks. The patient was evaluated for follow-up for his left knee. The patient was noted to have underlying comorbidities of type 2 diabetes mellitus and hypertension. The patient reported having intermittent pain to his left knee. The patient was requesting possible injections to the knee. The patient reported having clicking and popping occasionally. The pain to the knee increase when walking up and down stairs. The knee was stable and did not buckle. The objective findings on examination included overall appearance of left knee is unremarkable; ambulates without difficulty; full range of motion of his knee; tenderness at the medial joint line and over the medial femoral condyle anterior drawer, signs of Lachman are both negative; crepitus noted; and neurovascular status was intact. The diagnosis was degenerative changes of the left knee; s/p left knee arthroscopy; internal derangement left knee. The patient was prescribed Norco 10/325 mg; Prilosec 20 mg; Naproxen 550 mg; Temazepam 15 mg; Lorazepam 1 mg; and Lisinopril 10 mg for hypertension. The treatment plan included the prescription for the Aqua relief system x30 day rental directed to the left knee.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME: Aqua relief system x 30 days rental for left 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, Continuous Flow Cryotherapy

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 300, 338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and leg chapter, cold heat packs; continuous flow cryotherapy; Low back chapter cold/head packs

**Decision rationale:** The use of the cold/hot circulation units with a wrap are recommended by evidence-based guidelines for hospital use but not for home use. There is no demonstrated medical necessity for this cold/hot therapy unit with appliance to be provided to the patient directed to the left knee for home treatment as opposed to the conventional treatment with cold/hot packs. The medical necessity of the DME for the home treatment of the patient was not supported with objective evidence to support medical necessity. There is no objective evidence to support the home use of the requested cold/hot therapy system as opposed to the customary rest, ice, compression, and elevation (RICE) for the treatment of pain and inflammation to the left knee. There was no clinical documentation provided to support the medical necessity of the requested DME in excess of the recommendations of the California MTUS. The use of a cold/hot circulation pump is not demonstrated to be medically necessary for the treatment of chronic knee pain attributed to osteoarthritis (OA) of the knee. The Aqua therapy unit is recommended for diabetic care and is not demonstrated be medically necessary for the treatment of OA of the knee. There is no demonstrated medical necessity for the 30-day rental of a cold/hot circulation unit for the treatment of the knee for the cited diagnoses. The cold/hot therapy units are not medically necessary for the treatment of the postoperative knee for OA as alternatives for the delivery of heat and cold to the knee are readily available. The request for authorization of the cold/hot therapy by name brand is not supported with objective medically based evidence to support medical necessity. There is no provided objective evidence to support the medical necessity of the requested cold/hot unit as opposed to the more conventional methods for the delivery of cold/hot for the cited OA of the left knee. The CA MTUS, the ACOEM Guidelines, and the ODG recommend hot or cold packs for the application of therapeutic cold/hot or heat. The use of hot or cold/hot is not generally considered body part specific. The Official Disability Guidelines chapter on the knee and lower back states a good example of general use for hot or cold. The issue related to the request for authorization is whether an elaborate mechanical compression devise is necessary as opposed to the recommended hot or cold pack. There is no demonstrated medical necessity for the requested cold/hot unit for the treatment of the postoperative lumbar spine. There is no demonstrated medical necessity for the requested hot/cold unit 30-day rental for the treatment of the reported chronic knee pain for the diagnosis of osteoarthritis six years after the date of injury.