

Case Number:	CM15-0027977		
Date Assigned:	02/20/2015	Date of Injury:	06/29/2006
Decision Date:	04/02/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	02/13/2015

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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

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 71 year old male with an industrial injury dated 06/29/2006. The injured worker presented on 12/08/2014 with complaints of left knee pain rated 10/10 and severe right shoulder pain. Right shoulder range of motion was decreased. Empty can, supraspinatus and impingement tests were positive. There was tenderness of the knees in the medial joint line and lateral joint line to the left. Prior treatments included medications, physical therapy and surgery. The injured worker states he has a pacemaker and cannot have an MRI. Diagnoses included: Status post right shoulder surgery times 2. Right shoulder rotator cuff tear. Status post left total knee replacement surgery in 2009 with midflexion instability. Adhesive capsulitis, left knee. Left knee arthrofibrosis. Left knee revision surgery was requested along with durable medical equipment to include a cold therapy unit. On 01/26/2015 the request for cold therapy unit was non-certified by utilization review. "As the requested surgical procedure was deemed not medically necessary, then the requested cold therapy unit would also be deemed not medically necessary. ODG was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Durable Medical Equipment: 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 Disability Guidelines, (19th annual edition) & Official Disability Guidelines Treatment in Workers Compartment (12th annual edition) 2014, chapter knee.

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

Decision rationale: MTUS does not specifically address cold therapy units, therefore the Official Disability Guidelines (ODG) were referenced. ODG states that "postoperative use of continuous-flow cryotherapy units generally may be up to 7 days, including home use." There is no evidence in the guidelines for use after the initial 7 days nor do the guidelines recommend an unspecified duration. The employee is beyond the 7 day window after his surgery. At this time, the requesting provider is also requesting authorization for a repeat left knee surgery and there is no evidence at this time whether this was approved or not. As such, Durable Medical Equipment: Cold Therapy Unit is not medically necessary and appropriate.