

<b>Case Number:</b>	CM15-0070019		
<b>Date Assigned:</b>	04/17/2015	<b>Date of Injury:</b>	05/01/2014
<b>Decision Date:</b>	05/29/2015	<b>UR Denial Date:</b>	04/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/13/2015

### 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: California, Arizona  
 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 65-year-old female who reported an injury on 05/01/2014. The mechanism of injury was not provided. Her diagnoses was noted as chondromalacia of patella. During the assessment on 03/20/2015, the injured worker complained of ongoing knee pain. The physical examination of the right lower extremity demonstrated positive medial and lateral joint line tenderness to palpation. There was a positive McMurray's sign. There was significant knee effusion with soft tissue swelling. There was fullness in the back of the knee consistent with a Baker's cyst. The knee was stable both to varus and valgus stress, as well as anterior and posterior stress. There was a negative Lachman's, anterior drawer, and posterior drawer, all with firm endpoints. It was noted that an MRI of the right knee was noted to reveal lateral meniscus diffuse degeneration and diffuse tears, lateral compartment with moderate degenerative osteoarthritis, medial meniscus with diffuse intrasubstance degeneration, and graded posterior horn with small horizontal tears with the body possible extending to the posterior horn. The treatment plan was to request authorization that the injured worker undergo a right knee arthroscopic partial medial and lateral meniscectomy on an outpatient basis. It was also noted that the patient would require Norco for breakthrough pain postoperatively. The rationale for the requested cold compression therapy was not provided. The Request for Authorization form was not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**2 Weeks rental of cold compression therapy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability 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 & Leg, Continuous-flow cryotherapy.

**Decision rationale:** The request for 2 weeks rental of cold compression therapy is not medically necessary. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. While the cold compression therapy is indicated for postoperative use, the clinical documentation did not indicate that the requested surgery had been authorized or performed. Additionally, the rental for the cold compression therapy exceeds guideline recommendation. Given the above, the request is not medically necessary.

**60 Tablets of norco 5mg/325mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75, 78, 91.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, on-going management Page(s): 78.

**Decision rationale:** The request for 60 tablets of Norco 5/325 mg is not medically necessary. The California MTUS Guidelines state that ongoing management of opioid use should include documentation of pain relief, functional status, side effects, and appropriate medication use with the use of random drug screening as needed to verify compliance. However, the clinical documentation indicated the use of the Norco 5/325 mg was to be used postoperatively for breakthrough pain. The clinical documentation did not indicate that the requested surgery had been authorized or performed. As such, the request for postoperative medication is not supported. Given the above, the request is not medically necessary.