

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient is a 49-year-old woman. Her underlying date of injury is 04/13/2010, with the mechanism of injury that she slipped in a hallway and fell on her hands and experienced pain in her neck and back and knees. The diagnoses include a diagnosis of right knee chondromalacia patella status post a medial and lateral meniscectomy. As of 07/25/2013, the patient reported ongoing pain in her neck, back, and knees. Cervical and physical examination findings included crepitus in the knees and a positive patellofemoral grind bilaterally and a trace effusion at the right knee with functional range of motion.

An initial physician reviewer noted that the patient was to undergo repeat right knee arthroscopy 09/04/2013 and that guidelines would support a 7-day postoperative rental of a cryotherapy unit but not a purchase. This initial physician reviewer also noted that there was no indication that a bone stimulator was indicated for the planned osteotomy of the right tibial tubercle.

IMR DECISION(S) AND RATIONALE(S)

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

1. Postoperative cold therapy unit - purchase is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic), which is not part of the MTUS.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 3, page 48 and the Official Disability Guidelines (ODG), Knee Chapter, Continuous-flow cryotherapy.

The Physician Reviewer's decision rationale:

This treatment is not specifically address in the Medical Treatment Utilization Schedule. However, Official Disability Guidelines/Treatment of Workers' Compensation/Knee states regarding continuous flow cryotherapy, "Postoperative use may generally be up to 7 days including home use." The guidelines do not support the purchase of a cold therapy unit. This is consistent with general guidelines in ACOEM Guidelines Chapter 3, Page 48, which states, "During the acute to subacute phases for a period of 2 weeks or less, physicians can use passive modalities such as application of heat or cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise." The guidelines therefore support the use of short-term cold therapy without purchase of durable medical equipment for cold therapy. Therefore, I recommend this request be noncertified.

2. Postoperative bone stimulator rental unit for four (4) weeks is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic), which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), Knee Chapter, Electric bone growth stimulators.

The Physician Reviewer's decision rationale:

This request is not specifically discussed in the Medical Treatment Utilization Schedule. The Official Disability Guidelines/Treatment of Workers' Compensation/Knee states regarding electrical bone growth stimulators that this equipment is recommended for very specific situations including "nonunion of long bone fracture...the 2 portions of the bone must be separated by less than 1 cm...a minimum of 90 days has elapsed from the time of the original fracture and serial radiographs over 3 months show no progressive signs of healing except in the case of when the bone is infected." The medical records in this case do not meet these criteria. Rationale for the requested bone stimulator rental is not apparent, as the patient's planned surgery does not support indication for a bone growth stimulator. Therefore, this request is not medically necessary.

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[REDACTED]

CM13-0018348