

<b>Case Number:</b>	CM14-0028858		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	07/14/2008
<b>Decision Date:</b>	09/08/2014	<b>UR Denial Date:</b>	02/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2014

### 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 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:

The injured worker is a 56-year-old female who reported an injury on 07/14/2008 due to a trip and fall. The injured worker reportedly sustained an injury to her knees, arms, elbows, and wrists. The injured worker's treatment history included medications, bracing, injections, physical therapy, and a home exercise program. The injured worker was evaluated on 12/03/2013. It was noted that the injured worker had significant knee pain and objective findings to include right sided tenderness over the quadriceps and medial joint line tenderness of the right knee. The injured worker's diagnoses included medial and lateral tear of the meniscus bilaterally, osteoarthritis of the bilateral knees, left knee surgical intervention, right knee surgical intervention, overuse syndrome of the bilateral upper extremities, DeQuervain's tendinitis of the bilateral wrists, and carpal tunnel syndrome of the bilateral wrists. The injured worker's treatment plan included continuation of medications and a knee brace and use of a continuous cold therapy unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**COLD THERAPY UNIT FOR KNEES:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment for Workers Compensation, online edition, Chapter Shoulder, Continuous Flow Cryotherapy.

**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 chapter, Continuous Flow Cryotherapy.

**Decision rationale:** The requested cold therapy unit for the knees is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not specifically address this request. Official Disability Guidelines recommend a continuous flow cryotherapy unit for up to 7 days of management of postsurgical pain. The clinical documentation submitted for review does not provide any evidence that the patient is a surgical candidate at this time, or that surgery has been authorized or scheduled. Official Disability Guidelines do not recommend a continuous flow cryotherapy unit in the absence of surgical intervention. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not clearly identify duration of treatment or whether the durable medical equipment requested is for purchase or rental. As such, the requested cold therapy unit for the knees is not medically necessary or appropriate.