

<b>Case Number:</b>	CM14-0127590		
<b>Date Assigned:</b>	08/15/2014	<b>Date of Injury:</b>	05/01/2012
<b>Decision Date:</b>	01/31/2015	<b>UR Denial Date:</b>	07/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/11/2014

### 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 Rehab, has a subspecialty in Interventional Spine 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 patient is a 53 year old male with an injury date on 05/01/2012. Based on the 07/16/2014 progress report provided by the treating physician, the diagnoses are: 1. Right shoulder AC arthrosis 2. Right shoulder s subacrominal bursitis and impingement 3. Right shoulder rotator cuff tear 4. Right knee oblique tears 5. Right knee medial meniscal tears 6. Left knee oblique tear 7. Left knee medial meniscal tears 8. Eye pain According to this report, the patient complains of 7-8/10 burning or stabbing pain in the bilateral shoulder with 0% improvement, 7-8/10 bilateral knee pain with 0% improvement, and bilateral eye pain. Pain is increased with activity or sleeping on the shoulder, weight bearing activities such as walking. The patient utilizes a cane for ambulation on occasion. Physical exam reveals tenderness over the right AC joint, right bicipital groove, and medial/ lateral joint lines of the left knee. Range of motion of the right shoulder is restricted with pain. There is positive patellofemoral crepitus with motion in the bilateral knee. Neer's, Hawkin's, Cross arm test, and right McMurray's test are positive. Treatment to date includes physical therapy "which had been of minimally helpful" and medications which "helps increase his activity level by approximately 20%." The treatment plan is "to plan on operative treatment consisting of left knee arthroscopy and medial meniscectomy;" request for pre-op studies-CXR, EKG, Labs; and post operative medications and physical therapy. The patient's work status is "Temporary Partial Disability." There were no other significant findings noted on this report. The utilization review denied the request for Cold Therapy Unit Rental on 07/24/2014 based on the ODG guidelines. The requesting physician provided treatment reports from 06/24/2013 to 07/29/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold Therapy Unit Rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter online for DME knee chapter under continuous-flow cryotherapy.

**Decision rationale:** According to the 07/16/2014 report, this patient presents with 7-8/10 burning or stabbing pain in the bilateral shoulder with 0% improvement, 7-8/10 bilateral knee pain with 0% improvement, and bilateral eye pain. The current request is for Cold Therapy Unit Rental. Regarding cold therapy, ODG guidelines "recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." Review of the provided medical recorded, the treating physician documented on the 07/29/2014 report, that he obtained a "tentative verbal approval for proceeding with the right knee arthroscopy." In this case, given that the patient is approved for surgery; the use of Cold Therapy is supported by the guidelines. However, the treating physician does not specify the number of days requested. ODG supported the use of cold therapy up to 7 days for postoperative use. Without knowing the number of days requested; the request is not medically necessary.