

<b>Case Number:</b>	CM14-0213435		
<b>Date Assigned:</b>	12/30/2014	<b>Date of Injury:</b>	12/07/2005
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	11/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2014

### 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. 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

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

### 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 64-year-old female who reported an injury on 12/07/2005. The mechanism of injury was not provided. On 07/30/2014, the patient presented with complaints of bilateral shoulder and bilateral knee pain. Patient was reported to have had at least 6 sessions of chiropractic therapy. It was also noted that acupuncture therapy to the bilateral knees and shoulder provided temporary relief of pain. The patient had previous injections to the knees; some pain relief. Medications included gabapentin, aspirin and Motrin. Upon examination, there was tenderness to palpation over the anterior and posterior aspects of the shoulder. There was no skin hypersensitivity and no pain with range of motion. Examination of the left shoulder was within normal limits. The diagnoses were right knee medial meniscal tear and bilateral knee degenerative disc disease. The provider recommended ice therapy cold compression therapy for 3 weeks. There was no rationale provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ice therapy; cold compression therapy for 3 weeks: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Continuous Flow Cryotherapy.

**Decision rationale:** The request for ice therapy; cold compression therapy for 3 weeks is not medically necessary. The California MTUS/ACOEM Guidelines state that ice is recommended for nonspecific knee pain. The Official Disability Guidelines further state that continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use is up to 7 days, including home use. The provider's request for cryotherapy for 3 weeks would exceed the guideline recommendations. Additionally, the side at which the cryotherapy unit was indicated for was not provided in the request as submitted. As such, the request is not medically necessary.