

<b>Case Number:</b>	CM15-0021352		
<b>Date Assigned:</b>	02/10/2015	<b>Date of Injury:</b>	04/23/2013
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/04/2015

### 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

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 34-year-old female, who sustained an industrial injury on 4/23/13. She has reported and knee pain. The diagnoses have included headache, cervical sprain/strain, and cervical disc protrusion, thoracic sprain/strain, lumbar sprain/strain, and bilateral shoulder sprain/strain, bilateral acromioclavicular joint osteoarthritis, left shoulder infraspinatus tendinitis, right shoulder sub coracoid fluid, may relate to bursitis, bilateral mild carpal tunnel syndrome, bilateral knee sprain, and loss of sleep. Treatment to date has included diagnostic arthropathy, left partial lateral meniscectomy, physical therapy, aqua therapy, and medications. Currently, the injured worker complains of frequent and moderate neck pain with occasional moderate, dull, achy upper/mid back pain, stiffness, and cramping. Physical exam dated 12/8/14 revealed decreased and painful lumbar range of motion, tenderness to palpation of lumbar paravertebral muscles, left and right shoulder decreased range motion with pain and left and right knee decreased range of motion with pain. On 1/6/15 Utilization Review non-certified 4 months rental of hot and cold therapy unit with wrap, noting there is no indication for the requested four months rental, the surgery was performed 4 months prior. The MTUS, ACOEM Guidelines, was cited. On 1/28/15, the injured worker submitted an application for IMR for review of 4 months rental of hot and cold therapy unit with wrap.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **4 Months Rental of Hot and Cold Therapy Unit with Wrap: 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 Knee Chapter, page 292

**Decision rationale:** The patient underwent left partial lateral meniscectomy arthroscopy over 6 months ago. MTUS Guidelines is silent on specific use of cold compression therapy with pad and wrap, but does recommend standard cold pack for post exercise. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post knee surgery; however, limits the use for 7-day post-operative period, as efficacy has not been proven after. Submitted reports have not demonstrated medical necessity outside guidelines criteria for the 4 months of Hot/Cold unit rental. The 4 Months Rental of Hot and Cold Therapy Unit with Wrap is not medically necessary and appropriate.