

<b>Case Number:</b>	CM15-0164422		
<b>Date Assigned:</b>	09/01/2015	<b>Date of Injury:</b>	03/06/2014
<b>Decision Date:</b>	10/05/2015	<b>UR Denial Date:</b>	08/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/21/2015

### 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: New York, West Virginia, Pennsylvania  
 Certification(s)/Specialty: Emergency 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 54 year old female who sustained an industrial injury on 3-6-2014. She has reported lower back pain and hip pain and has been diagnosed with lumbar pain, sacral contusion, right hip pain, finding consistent with femoral acetabular impingement, and questionable capsular tear. Treatment has included surgery, injection, physical therapy, and medication. Lumbar examination revealed tightness in the back with poor forward flexion. She did walk with an antalgic gait. She had difficulty with body habitus with forward flexion. Paraspinal muscle spasm was present on the right side. Right straight leg raise was positive. Hip examination revealed tenderness on internal rotation and was very limited. She felt catching and locking in her right hip. There was tightness to the iliotibial band. The treatment plan included orthopedic consultation and medications. The treatment request included DME-Cryo Unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: Cryo unit (indefinite use): 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 (ODG-TWC) ODG Treatment Integrated Treatment/Disability Duration Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Integrated Treatment.

**Decision rationale:** Guidelines recommend cryo unit (indefinite use) as an option after surgery but not for non-surgical treatment. Postoperative use may be up to 7 days. In this case, postoperative use may be warranted. However, the request for cryo unit indefinite use is not medically appropriate and necessary.