

<b>Case Number:</b>	CM15-0195549		
<b>Date Assigned:</b>	10/09/2015	<b>Date of Injury:</b>	09/20/2005
<b>Decision Date:</b>	11/20/2015	<b>UR Denial Date:</b>	09/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/05/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 71-year-old male who sustained an industrial injury on 9/20/05. Injury was reported to the right upper extremity from repetitively stacking boxes weighing approximately 50 pounds above his shoulder. Past medical history was positive for diabetes and hypertension. The 3/4/15 EMG/NCV study evidenced moderate to severe right carpal tunnel and right ulnar neuropathy at the cubital tunnel. The 3/4/15 right shoulder MRI impression documented biceps tendinosis, early cystic degeneration of the greater tuberosity, acromioclavicular capsular inflammation, small subcoracoid effusion, and partial bursal surface rotator cuff tear. The injured worker underwent right carpal tunnel release on 7/18/15. Conservative treatment for the shoulder had included activity modification, 3 corticosteroid injections, and physical therapy. The 8/27/15 treating physician report cited persistent right shoulder pain and weakness. The injured worker was 5 weeks status post right carpal tunnel release. Physical exam documented right shoulder forward flexion from 0-170 degrees, external rotation from 0-40 degrees, and internal rotation to T12. There was a positive Hawkins sign with weakness in abduction testing. Authorization was requested for right shoulder arthroscopy with subacromial decompression and rotator cuff repair and an associated surgical request for Q-tech cold therapy unit 21-day rental. The 9/8/15 utilization review certified the request for right shoulder arthroscopy with subacromial decompression and rotator cuff repair. The request for Q-tech cold therapy unit 21-day rental was modified to continuous-flow cryotherapy for 7-days postoperatively.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Q-tech cold therapy unit 21 day rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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: Continuous flow cryotherapy.

**Decision rationale:** The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The 9/8/15 utilization review decision modified this request for a Q-tech cold therapy unit 21-day rental to continuous-flow cryotherapy for 7-days post-op use. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified or as an exception to guidelines. Therefore, this request is not medically necessary.