

<b>Case Number:</b>	CM15-0056567		
<b>Date Assigned:</b>	04/01/2015	<b>Date of Injury:</b>	03/27/2013
<b>Decision Date:</b>	05/05/2015	<b>UR Denial Date:</b>	03/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/25/2015

### 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:

The injured worker is a 60-year-old female who sustained an industrial injury on 3/27/13. The 2/19/15 treating physician report cited an onset of bilateral hip pain relative to working longer shifts and prolonged standing. She had progressive worsening hip pain to the point where she was barely able to walk due to pain. Pain was reported anterior with clicking, catching, and grinding. Ambulation was very limited with use of a cane. X-rays were obtained and showed severe destructive bone-on-bone arthritis of both hips, left worse than right. MRI findings had demonstrated severe degenerative changes in the femoral head and acetabulum consistent with degenerative joint disease. Physical exam documented limited hip range of motion with clicking and catching, and positive Stinchfield and FABER tests. Authorization was requested for bilateral total hip replacement and associated surgical items/services, including a cold therapy unit. The 3/11/15 utilization review certified the request for bilateral hip replacements and modified a request for cold therapy unit to 7-day rental consistent with guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold Therapy Unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee & Leg chapter - Continuous flow cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis: Cryotherapy; Knee and Leg: Continuous flow cryotherapy.

**Decision rationale:** The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous-flow cryotherapy is an option for up to 7 days in the post-operative setting following lower extremity surgery. The 3/11/15 utilization review decision recommended partial certification of a cold therapy unit for 7-day rental. 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. Therefore, this request is not medically necessary.