

<b>Case Number:</b>	CM14-0216679		
<b>Date Assigned:</b>	01/06/2015	<b>Date of Injury:</b>	06/21/2013
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	12/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/26/2014

### 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

### 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 is a 44 year old patient with date of injury of 06/21/2013. Medical records indicate the patient is undergoing treatment for a/p left shoulder arthroscopic partial thickness RTC tear, subacromial decompression, resection of coracoacromial ligament and resection of large subacromial spur and bursectomy and synovectomy; bilateral wrist ganglion, bilateral wrist carpal tunnel syndrome, bilateral shoulder bicipital tenosynovitis. Subjective complaints include bilateral shoulder pain radiating to wrist. Objective findings include tenderness, spasm, decreased range of motion, positive impingement, Phalen's and Tinel's test and decreased sensation at C6-C7. Treatment has consisted of surgical intervention, Omeprazole, Naproxen, Methoderm Gel, Calypso cream, Theramine, Trepadone, Sentra PM, Cyclobenzaprine, Norco and Xanax. The utilization review determination was rendered on 12/04/2014 recommending non-certification of Q-Tech cold therapy recovery system with wrap x 21 ay rental (retro distributed 10/29/2014).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective (DOS 10.29.14) Q-Tech cold therapy recovery system with wrap x 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 (ODG), Integrated Treatment/Disability Duration Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder, Cryotherapy

**Decision rationale:** MTUS does not specifically address cold therapy packs, therefore the Official Disability Guidelines (ODG) were referenced. ODG states that postoperative use of continuous-flow cryotherapy units generally may be useful for up to 7 days, including home use. There is no evidence in the guidelines for use after the initial 7 days. The requested duration is in excess of guideline recommendations. The original reviewer modified the request to 7 days. As such the request for Retrospective (DOS 10.29.14) Q-Tech cold therapy recovery system with wrap x 21 day rental is not medically necessary.