

<b>Case Number:</b>	CM15-0116594		
<b>Date Assigned:</b>	06/24/2015	<b>Date of Injury:</b>	09/21/2010
<b>Decision Date:</b>	07/23/2015	<b>UR Denial Date:</b>	05/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2015

### 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, Pain Management

### 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 53-year-old female, who sustained an industrial injury on 9/21/10. The injured worker has complaints of neck and left shoulder pain. The documentation noted that motion of the neck does cause painful symptoms and there is evidence of muscle spasm at the cervical spine. The diagnoses have included status post anterior and posterior lumbar interbody fusion 9/30/14; status post left L4-5 hemilaminotomy 2004; status post L3-4 laminectomy 3/20/12 and status post left carpal tunnel surgery 9/13/12. Treatment to date has included arthroscopic left rotator cuff repair, arthroscopic subacromial decompression, bursectomy and partial acromioplasty on 4/14/15; urine drug screen of 2/25/15 was consistent with current medications; norco and zanaflex. The request was for Q tech cold therapy system, 21-day rental with Wrap purchase, left shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Q Tech Cold Therapy System, 21 day rental with Wrap purchase, Left Shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder (acute & chronic) - Continuous flow cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation x Official Disability Guidelines (ODG), Shoulder Chapter, Cold compression therapy.

**Decision rationale:** Regarding the request for Q Tech Cold Therapy System, California MTUS and ACOEM do not contain criteria related to that request. ODG states that cold compression therapy is not recommended for the shoulder, as there are no published studies. As such, the currently requested Q Tech Cold Therapy System is not medically necessary.