

<b>Case Number:</b>	CM13-0035234		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	03/31/2006
<b>Decision Date:</b>	03/19/2014	<b>UR Denial Date:</b>	10/01/2013
<b>Priority:</b>	Expedited	<b>Application Received:</b>	10/28/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 43-year-old male who reported an injury on 3/31/06 due to cumulative trauma to the patient's right upper extremity. The patient underwent an MRI that revealed a 95% partial thickness supraspinatus tendon tear, biceps tenosynovitis, and acromioclavicular degenerative joint disease. The patient's most recent clinical examination findings included limited range of motion of the left shoulder described as 128 degrees in flexion, 40 degrees in extension, 110 degrees in abduction, 40 degrees in adduction, 50 degrees in internal rotation, and -6 degrees in external rotation. There was also 4/5 weakness in all planes, a positive impingement sign, and positive Kemp test. The clinical documentation submitted for review indicates that the patient was authorization for surgical intervention, and surgery was scheduled for 1/15/14. The patient's diagnoses included rotator cuff impingement syndrome and partial thickness tear. The patient's treatment plan included surgical intervention and postsurgical management.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**The request for a postoperative coolcase cold therapy unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. 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.

**Decision rationale:** The Official Disability Guidelines recommend the use of continuous flow cryotherapy units in the postsurgical management of a patient's pain for up to seven days. However, the purchase of this equipment is not supported by ODG recommendations, as it is only recommended for up to seven days of use. Although the clinical documentation submitted for review does indicate that the patient has been authorized for surgical intervention, the purchase of this unit is not indicated. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested postoperative cool case cold therapy unit is not medically necessary and appropriate.