

<b>Case Number:</b>	CM13-0038604		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	02/11/2010
<b>Decision Date:</b>	04/28/2014	<b>UR Denial Date:</b>	10/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/25/2013

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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/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:

This is a 39 year old female patient with a work-related injury reported on 02/11/2010 and the mechanism of injury was not provided. Diagnosis was superior glenoid labrum lesion. On 10/09/2013, the patient underwent a manipulation and steroid injection of the left shoulder, with arthroscopy and labral debridement of the left shoulder. On 12/16/2013, the patient was reportedly 9 weeks postop and range of motion was reportedly not consistent with a normal shoulder. Treatment plan was to repeat the manipulation with steroid injection physical therapy. On 01/26/2014, the patient presented, complaining of shoulder pain and lacking 20 degrees of full external rotation in abduction. The patient received a Kenalog injection into the intertuberosity notch, and the patient reported immediate pain relief. The patient reportedly continued with exercises/physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**COLD THERAPY UNIT RENTAL TIMES TWENTY -ONE DAYS AND PURCHASE OF CTU WRAP POST OP LEFT SHOULDER ARTHROSCOPY AND LABRAL DEBRIDEMENT:** Upheld

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

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

**Decision rationale:** The Official Disability Guidelines state cold therapy units are, "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be 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; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy (i.e., frostbite) are extremely rare but can be devastating." The Official Disability Guidelines support use of cryotherapy up to 7 days postop, and this request is for 21 days. Given that the request exceeds the recommended number of days for use, the request is not medically necessary and appropriate.