

<b>Case Number:</b>	CM13-0061333		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	07/31/2012
<b>Decision Date:</b>	05/13/2014	<b>UR Denial Date:</b>	11/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2013

### 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 Orthopedic Surgery 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 38-year-old male lifeguard sustained an accepted left shoulder injury on 7/31/12 when he lifted a child while teaching in a swimming camp. The 8/17/12 left shoulder MRI documented down sloping type II acromion and synovial hypertrophy with AC joint osteophyte formation causing moderate coracoacromial impingement, moderate intrasubstance delamination of the main body of the supraspinatus tendon, fraying of the bursal surface of the supraspinatus tendon, and modest subdeltoid bursitis. Failure of conservative treatment was documented. The 9/26/13 treating physician report indicated that the patient had not improved. There was complaint of moderate left shoulder pain that increased with activity. Objective findings documented slight anterior and mid cuff and AC joint tenderness, shoulder muscle atrophy, and global moderate loss of shoulder range of motion. A left shoulder arthroscopy with possible open rotator cuff repair was recommended and approved in utilization review. A TENS unit and cold therapy system with pad and wrap were requested for post-op use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 COLD THERAPY SYSTEM (PURCHASE): 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 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) SHOULDER, COLD COMPRESSION THERAPY; CONTINUOUS FLOW CRYOTHERAPY

**Decision rationale:** Under consideration is a request for purchase of a cold therapy system. The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines do not recommend cold compression therapy in the shoulder as there are no published studies. Continuous flow cryotherapy may be recommended as an option for post-operative use, up to 7 days. There is no compelling reason to support the purchase of a cold therapy system for this patient in the absence of support for cold compression and limited short-term support for continuous flow cryotherapy. Therefore, this request for purchase of a cold therapy system is not medically necessary.

**1 COLD THERAPY PAD AND WRAP (PURCHASE):** 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 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) SHOULDER, COLD COMPRESSION THERAPY; CONTINUOUS FLOW CRYOTHERAPY

**Decision rationale:** As the cold therapy system is not medically necessary, the request for one cold therapy wrap and pad is also not necessary.