

<b>Case Number:</b>	CM14-0157060		
<b>Date Assigned:</b>	09/30/2014	<b>Date of Injury:</b>	11/06/2013
<b>Decision Date:</b>	10/28/2014	<b>UR Denial Date:</b>	09/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2014

### 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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in Ohio. 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:

The injured worker is a 75-year-old female with a date of injury of 11-6-2013. The records reviewed include the notes from the utilization review nurse and some very brief notations from occupational medicine which are presumably postoperative. She has a history of prior rotator cuff surgery in 2000. On the current date of injury, she was involved in a motor vehicle accident. Apparently sometime had passed and ultimately an magnetic resonance imaging (MRI) scan of the right shoulder revealed a full thickness supraspinatus tendon tear with retraction and atrophy. The utilization review note references a preoperative history and physical exam which revealed diminished right shoulder range of motion, positive impingement signs, and tenderness. A right shoulder arthroscopy was planned according to this notation. No operative notes are available and no actual notations from a physician are available for review. This is a retroactive request for a continuous cryotherapy unit known as the Kodiak combo. At issue is whether or not the injured worker had the surgery and if the unit request was for rental or purchase.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro Kodiak combo multi use for the right shoulder E0218:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

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

**Decision rationale:** Continuous-flow cryotherapy 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 (eg, 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 documentation provided does not establish if surgery was performed or if the continuous flow cryotherapy unit was requested for rental or purchase. Because of the time constraints set by the above guidelines and the requirements that such units feel out for postoperative use only, the medical necessity for Kodiak combo multi use for the right shoulder cannot be established.