

<b>Case Number:</b>	CM14-0174364		
<b>Date Assigned:</b>	10/27/2014	<b>Date of Injury:</b>	05/16/2012
<b>Decision Date:</b>	12/04/2014	<b>UR Denial Date:</b>	09/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2014

### 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 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 is a 46-year-old male with a 5/16/12 date of injury. The mechanism of injury occurred when he tripped and fell over a trailer on his left side, injuring his left buttocks area, left leg, and left upper extremity. According to a progress report dated 9/10/14, the patient reported that his left shoulder and low back pain have not resolved. The provider has requested authorization for open subacromial decompression of the left shoulder and authorization for referral to a neurosurgeon regarding surgery to the lumbar spine. He has also requested authorization for cold unit to be used post-operatively. Objective findings: weakness about the rotator cuff of left shoulder, pain of left shoulder with motion, spasm noted about the lower lumbar region, point tenderness upon palpation of paraspinal region, decreased sensation to index, thumb, and middle fingers on left. Diagnostic impression: left shoulder impingement with tendinitis, lumbar spine herniated disc at L4-5 and L5-S1 with right-sided S1 radiculopathy. Treatment to date: medication management, activity modification. A UR decision dated 9/27/14 denied the request for post-operative cold therapy unit. However, with the patient not authorized to undergo the requested surgical procedure, the subsequent request for continuous flow cryotherapy is not supported.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: Post-operative cold therapy unit purchase for the left shoulder:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-214, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Continuous Flow Cryotherapy, and Continuous Passive Motion Device

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

**Decision rationale:** CA MTUS does not address this issue. ODG states that continuous-flow cryotherapy is 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 present case, this is a request for post-operative use. However, it is unclear if the requested surgical procedure has been authorized. As a result, this associated request cannot be substantiated at this time. In addition, this is a request for the purchase of a cold therapy unit, and guidelines only support rental for up to 7 days postoperatively. Therefore, the request for associated surgical service: Post-operative cold therapy unit purchase for the left shoulder was not medically necessary.