

<b>Case Number:</b>	CM14-0177500		
<b>Date Assigned:</b>	10/30/2014	<b>Date of Injury:</b>	10/20/2011
<b>Decision Date:</b>	12/08/2014	<b>UR Denial Date:</b>	09/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management, 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 male patient with the date of injury of October 20, 2011. A Utilization Review dated September 30, 2014 recommended non-certification of retro DME: motorized cold therapy unit purchase. An Operative Report dated May 16, 2014 identifies the patient underwent diagnostic arthroscopy, debridement of superior labral tear, debridement of hypertrophic synovitis, lysis of adhesions in the subacromial space, arthroscopic bursectomy, arthroscopic decompressive acromioplasty, and "mini" open rotator cuff repair.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective motorized cold therapy unit, provided on September 26, 2014:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Regarding the request for retrospective motorized cold therapy unit, provided on September 26, 2014, ODG cites that continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use, but not for non-surgical

treatment. Within the documentation available for review, the patient underwent surgery on May 16, 2014. There is no indication as to why the cold therapy unit was provided so late after surgery. Additionally, there is no indication as to how long the unit is to be used. As such, the currently requested retrospective motorized cold therapy unit, provided on September 26, 2014 is not medically necessary.