

<b>Case Number:</b>	CM14-0029010		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	07/03/2013
<b>Decision Date:</b>	07/16/2014	<b>UR Denial Date:</b>	02/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2014

### 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 58-year-old female warehouse worker sustained an industrial injury on 7/3/13, when she tripped over a pallet falling backwards. The 11/6/13 right shoulder MRI impression documented near full-thickness articular surface tear of the supraspinatus tendon, high grade partial thickness tear of the subscapularis tendon, and longitudinal tear of the biceps tendon. The 11/6/13 left shoulder MRI documented supraspinatus tendinosis and mild acromioclavicular joint degenerative changes. The 12/27/13 initial orthopedic report cited constant bilateral shoulder pain and instability, left greater than right. Pushing, pulling, lifting, and carrying aggravated her symptoms. Shoulder exam findings documented localized tenderness, moderate loss of flexion, extension, and abduction bilaterally, and marked loss of internal rotation bilaterally. The 1/24/14 orthopedic report documented a positive right shoulder injection test. The treatment plan recommended a right shoulder arthroscopy with arthroscopic subacromial decompression, and debridement versus repair of a partial rotator cuff tear. The 2/12/13 utilization review approved the request for right shoulder arthroscopic surgery. The associated post-operative request for ThermoCool hot and cold contrast therapy with compression for 60 days was certified with modification to 7 days.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**THERMOCOOL HOT AND COLD CONTRAST THERAPY WITH COMPRESSION X 60 DAYS:** Upheld

**Claims Administrator guideline:** The Claims Administrator 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.

**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 ThermoCool hot and cold contrast therapy with compression x 60 days. The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines do not recommend cold compression therapy in the shoulder but state that continuous-flow cryotherapy is an option for up to 7 days. The 2/12/13 utilization review decision recommended partial certification of the ThermoCool unit for 7-days use. There is no compelling reason in the records reviewed to support the medical necessity of a cold therapy unit beyond the 7-day use recommended by guidelines and previously certified. Therefore, this request for ThermoCool hot and cold contrast therapy with compression x 60 days is not medically necessary.