

<b>Case Number:</b>	CM14-0042840		
<b>Date Assigned:</b>	06/30/2014	<b>Date of Injury:</b>	03/26/2003
<b>Decision Date:</b>	12/12/2014	<b>UR Denial Date:</b>	04/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/10/2014

### 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 & Rehabilitation 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:

The injured worker is a 57-year-old male who reported an injury on 03/26/2003 due to unspecified mechanism of injury. The injured worker complained of back pain, shoulder pain, and left hand pain. The injured worker had a diagnosis of shoulder arthritis. Past surgeries included a right shoulder arthroscopy with hardware removal. Treatments included physical therapy, medication and Orthovisc injection that failed. Diagnostics included an unofficial MRI dated 2010 and an unofficial MRI dated 2013 that were not provided. Medications included oxycodone. The clinical notes dated 06/04/2014 did not provide objective findings. Request for Authorization dated 04/22/2014 was submitted with documentation. The treatment plan included cold therapy unit 14 day rental.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold Therapy Unit, 14 day rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment for Workman's Compensation Treatment Guidelines 2012, Integrated Treatment/Disability Duration Guidelines: Shoulder (Acute & Chronic)

**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

**Decision rationale:** The request for Cold Therapy Unit, 14 day rental is not medically necessary. The Official Disability Guidelines indicate 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 preoperative setting, continuous flow therapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. However, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. The continuous flow cryotherapy unit provides regulated temperatures through use of power to circulate ice water to the cooling packs. Complications related to cryotherapy are extremely rare but can be devastating. The request is for a 14 day rental that exceeds the recommended time. Per the guidelines, cryotherapy is an option after surgery. As such, the request is not medically necessary.