

<b>Case Number:</b>	CM14-0152273		
<b>Date Assigned:</b>	10/02/2014	<b>Date of Injury:</b>	02/20/2013
<b>Decision Date:</b>	01/09/2015	<b>UR Denial Date:</b>	09/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2014

### 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 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 patient sustained an injury on 2/20/13. Request(s) under consideration include Post-op cold therapy unit 14 day rental. Diagnoses include right shoulder full thickness retracted rotator cuff tear, AC joint osteoarthritis. Conservative care has included medications, therapy, and modified activities/rest. The patient exhibit right shoulder pain and weakness with difficulty in overhead activity. Exam on 8/29/14 showed TTP over the AC joint; limited range of flex/ext/abd/IR/ER of 100/70/100/60/70 degrees. Treatment plan included right shoulder arthroscopy, possible synovectomy, labral repair, SAD, and distal clavicle excision with post-op therapy, right shoulder sling and cold therapy unit rental for 14 days. The request(s) for Post-op cold therapy unit 14 day rental was modified for 7 day rental on 9/5/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-op 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 (ODG) Shoulder

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 195-220.

**Decision rationale:** Regarding Cold therapy, guidelines state it is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. The request for authorization does not provide supporting documentation for rental beyond the guidelines criteria. There is no documentation that establishes medical necessity or that what is requested is medically reasonable outside recommendations of the guidelines. MTUS Guidelines is silent on specific use of cold compression therapy with pad and wrap, but does recommend standard cold pack for post exercise. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post-surgery; however, limits the use for 7-day post-operative period as efficacy has not been proven after. The Post-op cold therapy unit 14 day rental is not medically necessary and appropriate.