

<b>Case Number:</b>	CM14-0193825		
<b>Date Assigned:</b>	12/01/2014	<b>Date of Injury:</b>	04/08/2012
<b>Decision Date:</b>	01/30/2015	<b>UR Denial Date:</b>	10/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/19/2014

### 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 Minnesota. 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 35-year-old male with a date of injury of 4/8/2012. He underwent an MRI scan of the right shoulder on 8/14/2012 which showed a nondisplaced tear of the posterior superior labrum extending to the posterior labrum with a 4 mm peri-labral cyst. There was a 10 x 4 mm partial articular surface tear of the rotator cuff involving 10% of the tendon thickness there was mild-to-moderate diffuse tendinosis with mild bursal surface fraying. A request for surgery consisting of arthroscopy, decompression, and labral and rotator cuff repairs has been certified. The disputed issue pertains to purchase of a continuous flow cryotherapy unit for postoperative use. This was noncertified by utilization review citing ODG guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical services: Cold Flow Unit - Purchase:** 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, 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) Section: Shoulder, Topic: Continuous flow cryotherapy.

**Decision rationale:** California MTUS does not comment on this issue. ODG guidelines are therefore used. Continuous flow cryotherapy is recommended as an option after shoulder surgery. The use is generally for 7 days. It reduces swelling, inflammation, and pain, and cuts down the need for narcotics after surgery. A 7 day rental is appropriate and medically necessary per guidelines; however, use after 7 days is not recommended. Therefore the request as stated for purchase of the cold flow unit is not supported by guidelines and as such, the medical necessity of the request is not established.