

<b>Case Number:</b>	CM14-0208950		
<b>Date Assigned:</b>	12/22/2014	<b>Date of Injury:</b>	09/16/1998
<b>Decision Date:</b>	02/27/2015	<b>UR Denial Date:</b>	12/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/15/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Injured worker is a female with date of injury 9/16/1998. Per primary treating physician's progress report dated 9/10/2014, the injured worker notes no significant improvement of the pain in her right shoulder following a recent cortisone injection and time off work. She notes ongoing difficulty with reaching overhead or reaching behind her. On examination she has tenderness over the right shoulder. Right shoulder range of motion is forward flexion 160 degrees and abduction 140 degrees. There is positive impingement sign and positive abduction sign. Diagnoses include 1) carpal tunnel syndrome 2) rotator cuff syndrome NOS 3) lesion of ulnar nerve 4) medial epicondylitis 5) cervicalgia 6) spasm of muscle 7) lateral epicondylitis 8) tenosynovitis hand/wrist.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-op Right Shoulder Cold Therapy Unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**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, Cold Compression Therapy section, Continuous-flow Cryotherapy section.

**Decision rationale:** The MTUS Guidelines do not address the use of cold compression therapy for the shoulder. The ODG does not recommend the use of cold compression therapy for the shoulder as there are no published studies. Continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to seven days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The requesting physician explains that the injured worker has failed conservative treatment and is recommended for right shoulder arthroscopy subacromial decompression, debridement calcific tendinitis, possible rotator cuff repair, possible SLAP lesion repair, possible open biceps tenodesis, and excision distal clavicle. The request for cold therapy unit does not specify purchase or rent, or how long the unit will be utilized. The ODG recommends up to seven days of use postoperatively, including home use. Medical necessity has not been established without specifying the length of use. The request for Post-op Right Shoulder Cold Therapy Unit is determined to not be medically necessary.