

<b>Case Number:</b>	CM15-0102905		
<b>Date Assigned:</b>	06/05/2015	<b>Date of Injury:</b>	11/21/2014
<b>Decision Date:</b>	07/09/2015	<b>UR Denial Date:</b>	05/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/28/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 41 year old male, who sustained an industrial injury on 11/21/14. He reported pain in the back, right shoulder, and legs. The injured worker was diagnosed as having cervicothoracic strain/mild arthrosis, right shoulder rotator cuff tears, right knee strain/contusion, left ankle strain/sprain/contusion, and status post motor vehicle accident with wide ranging sprain/strain/contusions. Treatment to date has included physical therapy, a home exercise program and medication. Currently, the injured worker complains of right shoulder pain. The treating physician requested authorization for a cold therapy unit purchase. The treatment plan included arthroscopic subacromial decompression, rotator cuff repair and treatment of all the pathologies including potential open subpectoralis biceps tenodesis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold Therapy 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 Chapter, 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 (Acute & Chronic), continuous flow cryotherapy.

**Decision rationale:** The claimant sustained a work-related injury in November 2014 and continues to be treated for right shoulder pain. A rotator cuff decompression and repair is being planned. There is a full thickness supraspinatus tear. Authorization for a cold therapy unit post-operatively was requested. Continuous flow cryotherapy is recommended as an option after surgery, with postoperative use generally up to 7 days, including home use. In this case, purchase of a unit for indefinite use is being requested which is not medically necessary.