

<b>Case Number:</b>	CM15-0221998		
<b>Date Assigned:</b>	11/17/2015	<b>Date of Injury:</b>	04/07/2015
<b>Decision Date:</b>	12/24/2015	<b>UR Denial Date:</b>	10/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/10/2015

### 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: Montana, Oregon, Idaho

Certification(s)/Specialty: Orthopedic Surgery

### 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 34 year old male, who sustained an industrial injury on 4-7-2015. The medical records indicate that the injured worker is undergoing treatment for right shoulder impingement syndrome and acromioclavicular joint arthritis. According to the progress report dated 9-2-2015, the injured worker presented with complaints of severe pain in his right shoulder. The level of pain is not rated. The physical examination of the right shoulder reveals tenderness over the acromioclavicular joint, greater tuberosity, and subacromial space. He has a positive Hawkin's, Neer, and cross-body adduction test. The current medications are Relafen. Previous diagnostic studies include MRI of the right shoulder. The treating physician describes the MRI as "acromioclavicular joint arthritis and rotator cuff tendinitis". Treatments to date include medication management, activity modification, physical therapy, and injection. Work status is described as "return to work with restrictions". The treatment plan included right shoulder arthroscopy with subacromial decompression and distal clavicle excision. The original utilization review (10-20-2015) partially approved a request for a seven day rental for a cold therapy unit for the right shoulder (original request was for cold therapy unit purchase).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: Purchase of Cold Unit for the Right Shoulder: 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) shoulder.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, 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 postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy (i.e, frostbite) are extremely rare but can be devastating. In this case, a cold therapy unit is recommended for no more than 1 week according to the cited guidelines. As this request is for a purchase of the unit, the request does not meet criteria set forth in the guidelines and therefore the request is not medically necessary.