

<b>Case Number:</b>	CM15-0075215		
<b>Date Assigned:</b>	04/27/2015	<b>Date of Injury:</b>	02/10/2014
<b>Decision Date:</b>	08/05/2015	<b>UR Denial Date:</b>	03/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/20/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 49 year old female, who sustained an industrial injury on February 10, 2014. She reported left shoulder pain with the feeling of a pop type sensation. The injured worker was diagnosed as having persistent left shoulder pain, impingement syndrome and ACL arthrosis with partial labral tear. Treatment to date has included diagnostic studies, injections and physical therapy without relief. On March 6, 2015, the injured worker complained of persistent left shoulder pain with clicking and popping on the shoulder. Physical examination of the left shoulder revealed positive Impingement pain with cross chest, tenderness over the AC joint, pain with extension and pain with O'Brien. Strength was noted to be good. Notes stated that she has tried all conservative measures of therapy with no significant improvement. The treatment plan included left shoulder arthroscopy, subacromial decompression, distal clavicle resection and possible SLAP debridement versus repair. On March 24, 2015, Utilization Review non-certified the request for peer to peer cold therapy, citing the Official Disability Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold therapy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 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 Chapter, pages 909-910.

**Decision rationale:** Treatment plan included left shoulder arthroscopy. Current request was modified for 7day post-op use of cold therapy unit. 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. Submitted reports have not provided adequate documentation, risk factors, or comorbidities to support for the request beyond 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 the specific use of cold unit care, 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 in the post-operative period as efficacy has not been proven after. The unspecified Cold therapy is not medically necessary and appropriate.