

<b>Case Number:</b>	CM14-0145966		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	07/17/2012
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	09/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2014

### 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 Occupational Medicine and is licensed to practice in California. 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic shoulder pain reportedly associated with an industrial injury of July 17, 2012. Thus far, the applicant has been treated with the following: Analgesic medications; earlier shoulder rotator cuff repair surgery; unspecified amounts of physical therapy; and subsequent manipulation under anesthesia surgery on April 29, 2014. In a Utilization Review Report dated September 4, 2014, the claims administrator approved an arm sling, approved seven days of continuous-flow cryotherapy, and denied request for purchase of a cold therapy unit and/or Kodiak combination stimulator device. The applicant's attorney subsequently appealed. In a progress note dated July 29, 2014, the applicant was described as status post shoulder arthroscopy, debridement, lysis of adhesions, and manipulation under anesthesia surgery. The applicant was reportedly improving nicely. The applicant was returned to modified duty work. On June 20, 2014, however, the applicant presented for a recheck. The applicant had apparently had issues with worsening stiffness about the arm, it was stated in one section of the report. In another section of the report, it was stated that the applicant was significantly better. The applicant was placed off of work, on total temporary disability, for four weeks, to facilitate performance of physical therapy. The operative report of April 29, 2014 was reviewed. The applicant underwent a shoulder arthroscopy, biceps tenolysis, extensive debridement, subacromial decompression, rotator cuff debridement, and manipulation under anesthesia surgery with lysis of adhesions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold Therapy Unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder (Acute and Chronic); Continuous-Flow Cryotherapy

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder Chapter, Continuous-flow Cryotherapy topic.

**Decision rationale:** 1. No, the cold therapy unit purchase was not medically necessary, medically appropriate, or indicated here. The MTUS does not address the topic of continuous-flow cryotherapy postoperatively. As noted in ODG's Shoulder Chapter, Continuous-flow Cryotherapy topic, continuous-flow cryotherapy is recommended as an option after surgery. ODG qualifies its recommendation by noting that postoperative use may generally be up to seven days by noting that complications associated with prolonged cryotherapy such as frostbite are extremely rare but can be devastating. In this case, no rationale for purchase of the cold therapy unit was proffered in the face of the unfavorable ODG position on the same. The attending provider did not clearly outline why a seven-day rental would not suffice here for postoperative use purposes. Therefore, the request was not medically necessary.

**Kodiak Combo multi Use, 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: Shoulder (Acute and Chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, POSTOPERATIVE PAIN Page(s): 116-117.

**Decision rationale:** 2. Similarly, the Kodiak combo stimulator/TENS device was likewise not medically necessary, medically appropriate, or indicated here. While page 116 of the MTUS Chronic Pain Medical Treatment Guidelines does support usage of TENS units for acute postoperative pain in the first 30 days following surgery, page 117 of the MTUS Chronic Pain Medical Treatment Guidelines qualifies the MTUS position by noting that rental would be preferred over purchase during the 30-day postoperative use window. The attending provider, however, seemingly sought authorization to purchase the device, despite the MTUS position that rental would be preferred for 30-day postoperative use purposes. Therefore, the request was not medically necessary.