

<b>Case Number:</b>	CM14-0215015		
<b>Date Assigned:</b>	01/07/2015	<b>Date of Injury:</b>	08/01/2014
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	12/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/22/2014

### 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: New York, Tennessee  
 Certification(s)/Specialty: Emergency 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:

The patient is a 69-year-old male who was injured on August 1, 2014. The patient continued to experience pain in his left shoulder. Physical examination of the left shoulder was notable for normal range of motion of the cervical spine, positive impingement sign on forward flexion, positive rent test, no motor deficits, no muscle atrophy, and no sensory deficits. MRI of the shoulder showed a full thickness tear of the supraspinatus and partial thickness tear of the posterior labrum. Diagnoses included left shoulder rotator cuff tear, biceps tenosynovitis, and left elbow medial and lateral epicondylitis. Treatment included medications and home exercise program. Request for authorization for cold therapy unit was submitted for consideration.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: 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 (ODG), TWC, Shoulder (Acute & Chronic)

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

**Decision rationale:** 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 the cold therapy unit is being requested for postoperative use. There is no documentation of the intended duration of use or whether the unit is to be rented or purchased. Insufficient documentation does not allow for determination of necessity. The request is not medically necessary.