

<b>Case Number:</b>	CM15-0110018		
<b>Date Assigned:</b>	06/16/2015	<b>Date of Injury:</b>	11/13/2012
<b>Decision Date:</b>	07/15/2015	<b>UR Denial Date:</b>	05/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/08/2015

### 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: Illinois, California, Texas  
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 53-year-old female who sustained an industrial injury on 11/13/12. Injury was reported real to repetitive typing. She underwent anterior cervical discectomy and fusion at C5/6 on 12/11/14. The 3/31/15 right shoulder MR arthrogram documented a focal full thickness tear of the distal supraspinatus tendon. Findings documented mild synovial acromioclavicular joint hypertrophy. The 4/20/15 treating physician report cited progressive worsening of her right shoulder pain that disturbed her sleep. Difficulty was reported in lifting her arm up, overhead activities, and activities of daily living. Conservative treatment had included activity modification, anti-inflammatory medications, exhaustive physical therapy, and 2 steroid injections with only temporary relief. Physical exam documented tenderness to palpation over the trapezius, acromioclavicular joint, and bicipital groove. Range of motion was documented as flexion 160, abduction 170, external rotation 70, and internal rotation to the iliac crest. Pain was reported at extremes of forward flexion and abduction. There was 3/5 supraspinatus weakness. Authorization was requested for right shoulder rotator cuff repair, subacromial decompression, distal clavicle resection, and partial acromioplasty with assistant surgeon. Associated surgical requests included rental of a cold therapy unit for an unspecified length of time. The 5/13/15 utilization review certified the request for right shoulder surgery and modified the non-specific request for cold therapy unit rental to 7 days.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: Rental of cold therapy unit: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: continuous flow cryotherapy.

**Decision rationale:** The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous-flow cryotherapy is an option for up to 7 days in the post-operative setting following knee surgery. The 5/13/15 utilization review modified the request for rental of a cold therapy unit for an unspecified length of time to 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.