

<b>Case Number:</b>	CM13-0033597		
<b>Date Assigned:</b>	12/06/2013	<b>Date of Injury:</b>	03/01/2007
<b>Decision Date:</b>	04/18/2014	<b>UR Denial Date:</b>	09/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/10/2013

### 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 Orthopedic Surgery and is licensed to practice in Georgia and Texas. 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 patient is a 54-year-old female who reported an injury on 03/01/2007. The mechanism of injury was not specifically stated. The patient is diagnosed with impingement syndrome, rotator cuff tendonitis, possible tear and internal derangement, and left shoulder adhesive capsulitis. A request for authorization for a ThermoCool system was submitted by [REDACTED] on 08/30/2013. However, there was no physician progress report submitted on the requesting date. An operative report was submitted on 09/07/2013 by [REDACTED], which indicated that the patient underwent left shoulder arthroscopy with synovectomy, lysis of adhesions, debridement of the labrum, subdeltoid bursectomy, lateral acromionectomy, lateral claviclectomy, and manipulation under anesthesia.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SIX WEEK RENTAL OF THERMACOOLER SYSTEM WITH PAD/WRAP FOR THE LEFT 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

**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, Continuous Flow Cryotherapy

**Decision rationale:** The Official Disability Guidelines indicate that continuous flow cryotherapy is recommended as an option after surgery. Postoperative use generally may be up to seven (7) days, including home use. As per the documentation submitted, the patient is status post left shoulder arthroscopy. However, the current request for a six (6) week rental exceeds guideline recommendations. Based on the clinical information received and the Official Disability Guidelines, the request is non-certified.