

<b>Case Number:</b>	CM13-0042672		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	02/20/2013
<b>Decision Date:</b>	05/22/2014	<b>UR Denial Date:</b>	10/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2013

### 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 Physical Medicine & Rehabilitation 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 injured worker is a 57-year-old male who reported an injury on 02/20/2013 due to a fall that reportedly caused injury to the injured worker's left shoulder and left hip. The injured worker was evaluated on 10/22/2013. It was documented that the injured worker had persistent shoulder pain complaints with evidence of a rotator cuff tear caused significant dysfunction and required surgical intervention. Physical findings included severely restricted range of motion of the left shoulder with positive tenderness of the subacromial bursa, acromioclavicular joint evidence of motor strength weakness in abduction and external rotation. The injured worker's diagnoses included massive rotator cuff tear with acute loss of function and inability to regain function of the left shoulder and chronic pain. The injured worker's treatment recommendations included left shoulder arthroscopic rotator cuff repair with postoperative physical therapy and a ThermoCool unit to assist in postoperative rehabilitation. The injured worker was evaluated again on 11/05/2013. It was documented that the injured worker had undergone surgical intervention on 10/31/2013 and continued to have left shoulder pain. However, it was considered to be improving.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**THERMOCOOL UNIT WITH COMPRESSION, 60 DAYS:** 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) Shoulder Chapter, 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, Continuous Flow Cryotherapy.

**Decision rationale:** The requested Thermocool unit with compression for 60 days is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address the use of cryotherapy units. Official Disability Guidelines recommend the use of continuous flow cryotherapy for up to 7 days in the postsurgical management of a shoulder injury. The request for 60 days of treatment exceeds this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested Thermocool Unit with compression for 60 days is not medically necessary or appropriate.