

<b>Case Number:</b>	CM13-0056296		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	05/29/2009
<b>Decision Date:</b>	11/06/2014	<b>UR Denial Date:</b>	11/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/22/2013

### 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 Pain Management 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 53-year-old male who sustained an injury on May 29, 2009. He is diagnosed with (a) L1-L2 laminotomy and microdiscectomy done on January 23, 2012; (b) acromioclavicular joint arthritis of the left shoulder; (c) depression; (d) bilateral hip degenerative joint disease; (e) L1-2 extruded disc herniation; (f) annular tears at L1-S1; (g) annular tear at L4-S1 with facet arthropathy; (h) L1-L2 and L2-L3 moderate lumbar stenosis; (i) right leg radiculopathy; (j) left shoulder impingement syndrome with lateral downsloping of the acromion; and (k) status post right-sided L1-L3 laminotomy and microdiscectomy done on January 19, 2012. He was seen for a follow-up evaluation on August 19, 2013. He had complaints of left shoulder pain, which increased with activity. Examination of the left shoulder revealed palpable tenderness over the left trapezius, anterolateral aspect of the shoulder, and over the left biceps. Range of motion was restricted. There was positive impingement sign noted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold therapy 30 day rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG TREATMENT 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, Continuous-flow cryotherapy

**Decision rationale:** Guidelines state that postoperative use of this modality is recommended for up to seven days only. Cold therapy unit was requested for 30 days, which is beyond the timeframe approved by the guidelines. Therefore, the request for a 30-day rental of a cold therapy unit is not medically necessary.

**Pad purchase for 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 (ODG)

**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:** As the request for 30-day rental of cold therapy unit was not considered medically necessary at this time, therefore the request for purchase of pad for the left shoulder is also not considered medically necessary.