

<b>Case Number:</b>	CM14-0104139		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	10/21/2011
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	06/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2014

### 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. The expert reviewer is Board Certified in Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 49 year old employee with date of injury of 10/21/2011. Medical records indicate the patient is undergoing treatment for s/p right shoulder arthroscopy (10/16/2013); osteoarthritis articular cartilage disorder; supraspinatus tendon tears and DJD in bilateral shoulders' paresthesia, bilateral upper extremities; carpal tunnel syndrome on the left and internal derangement of the left knee. Subjective complaints include shoulder pain at 6/10. She says she has muscle spasms and trouble sleeping with her shoulder. Her left shoulder pain is rated 5/10 and her wrist at 4/10. Her right knee pain is 2/10 because she compensates for the left knee which she rates 7/10 with spasms, weakness and sharp shooting pain. Objective findings include a positive bilateral Neer's test, positive 90 degree cross over impingement test, and positive Apley's and Hawkin's and weak abduction against shoulder resistance. The left is better than the right. Her right knee has 100/130 degrees flexion and extension 0/0. She has joint space tenderness, particularly in the medial joint spaces of bilateral knees. She has a positive McMurray's test bilaterally. Treatment has consisted of PT, Tramadol, Gabapentin, Soma and Relafen. The utilization review determination was rendered on 6/21/2014 recommending non-certification of a Post-operative micor cool machine for left shoulder (length not specified).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post operative micor cool machine for left shoulder (length not specified): 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) 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 (Acute & Chronic), Continuous-flow cryotherapy

**Decision rationale:** MTUS and ACOEM are silent regarding this topic. ODG states, "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."The patient was approved for shoulder surgery. Progress notes and request for authorization does not detail the length of time for the cold therapy unit. A 7 day post-operative time period is reasonable and within guidelines. The treating physician does not include additional information that would justify the use of a cold therapy unit in excess of the guideline recommendation. The original utilization review modified and approved a 7 day rental of cold therapy unit, which was appropriate. As such, the request for Post operative micor cool machine for left shoulder (length not specified) is not medically necessary.