

<b>Case Number:</b>	CM14-0105016		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	05/02/2012
<b>Decision Date:</b>	10/07/2014	<b>UR Denial Date:</b>	06/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/08/2014

### 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 General Surgery, has a subspecialty in Surgical Critical Care, and is licensed to practice in 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 injured worker is a 52-year-old male with a reported date of injury on May 2, 2012. The mechanism of injury is described as a bilateral shoulder injury after a 24-foot machine fell on him. Shoulder arthroscopy and hand surgeries for lacerations followed this event. A progress note dated May 14, 2014 noted complaints of left shoulder pain especially with overhead manipulation. The injured worker was noted to have failed conservative treatment with physical therapy and anti-inflammatories. The physical exam revealed positive Hawkins and Neer testing. Limited range of motion (ROM) at 150 is noted. Left shoulder arthroscopy was recommended for rotator cuff repair. On June 2, 2014, another treating physician noted complaints of neck pain with cervical spine ROM, flexion at 30/50, extension 40/60. This physician recommended no aggressive intervention for the injured worker's neck pain. On June 13, 2014, a third treating physician documented shoulder pain complaints with sleeping, walking, and sitting. Physical exam revealed reduced ROM of the left upper extremity which was associated with pain to the shoulder and wrist. The recommendation was for an over-the-counter men's daily vitamin, Aspirin, and Simvastatin 10mg. The current request is for post-operative cold compression durable medical equipment which was denied by prior utilization review on June 27, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post Op Durable Medical Equipment - ARS Hot/Cold Compression (6/19/14): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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

**Decision rationale:** This request for a cold compression therapy unit does not specify the length of use following shoulder surgery. ODG supports the use of a cryotherapy unit for 7 days post-operative use. Unlimited use is not medically necessary and not in keeping with ODG recommendations. Therefore, this request is not medically necessary.