

<b>Case Number:</b>	CM14-0117491		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	09/14/2012
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	07/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 48-year-old male who reported a slip and fall on 09/14/2012. On 06/20/2014, his diagnoses included right shoulder impingement syndrome and right shoulder superior labral tear from anterior to posterior (SLAP) tear type 2 confirmed by MRI, subacromial bursitis, distal supraspinatus tendinosis, and biceps tendinitis. The plan of care included right shoulder arthroscopic evaluation, arthroscopic subacromial decompression, distal clavicle resection, and labral debridement. The rationale for the requested cold therapy unit was that it would assist in managing postoperative swelling, edema, and pain. There is no Request for Authorization included in this injured worker's chart.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold Therapy Unit rental times 90 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-Treatment in Workers Compensation, Shoulder.

**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:** The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery. Postoperative use generally may be up to 7 days, including home use. The request for rental of this unit for 90 days exceeds the recommendation in the Guidelines of 7 days usage. There is no documentation submitted that the proposed surgery had every taken place. Additionally, the request did not include a part of the body to which this therapy unit was to have been applied. Therefore, the request for Cold Therapy Unit rental times 90 days is not medically necessary.