

<b>Case Number:</b>	CM14-0038837		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	09/04/2013
<b>Decision Date:</b>	08/15/2014	<b>UR Denial Date:</b>	03/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2014

### 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 and Rehabilitation and is licensed to practice in Nevada. 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 55 year-old female who was reportedly injured on 9/4/2013. The mechanism of injury is listed as a left shoulder injury that occurred when a sliding door came off the van that the injured worker was operating. The most recent progress notes dated 10/28/2013, 12/4/2013 and 3/19/2014, indicate that there are ongoing complaints of left shoulder pain and limited range of motion. Physical examination demonstrated tenderness to left shoulder and triceps; limited left shoulder range of motion with pain on flexion at 40, abduction at 40, internal rotation results in some pain, unable to externally rotate; neurovascularly intact; motor strength 5/5. Magnetic resonance image arthrogram of the left shoulder dated 2/21/2014 demonstrated partial labrum tear with possible glenolabral articular disruption lesion. Previous treatment includes subacromial shoulder injection, home stretching exercises and medications to include Motrin, Norco and Valium. A request was made for purchase of a cold therapy unit for 21 day rental and was partially certified for a seven-day rental in the utilization review on 3/20/2014. 6790

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase of a cold therapy unit for purchase or 21 day rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 555-556. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, 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) ODG -TWC/ODG Integrated Treatment/Disability Duration Guidelines; Shoulder (Acute & Chronic) - Continuous Flow Cryotherapy - (updated 7/29/14).

**Decision rationale:** Official Disability Guidelines guidelines support cryotherapy as an option after surgery, but not for nonsurgical treatment. Guidelines state that postoperative use generally may be up to 7 days, including home use. Arthroscopic subacromial decompression of left shoulder has been recommended in previously certified. The current request is for the purchase or 21 day rental of a cold therapy unit. As such, the current request is not considered medically necessary.