

<b>Case Number:</b>	CM14-0039995		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	11/01/2011
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	03/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/04/2014

### 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 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 records presented for review, indicate that this 32-year-old female was reportedly injured on November 1, 2011. The mechanism of injury was not listed in the records reviewed. The most recent progress note, dated May 28, 2014, indicated that there were ongoing complaints of bilateral upper extremity pain. The physical examination demonstrated decreased range of motion of the cervical spine with pain. There was tenderness over the trapezius region. Examination of the right shoulder noted atrophy and abduction limited to 75 . There were tenderness at the right acromioclavicular joint and a positive cross arm test. Weakness of the right rotator cuff was also observed. Diagnostic nerve conduction studies of the upper extremities were normal. Previous treatment included a right shoulder arthroscopy and decompression performed on February 26, 2014. There has also been a right ulnar nerve release and a right-sided carpal tunnel release. The injured employee was participating in postoperative physical therapy. A request was made for the purchase of a cold therapy unit and wrap for the right shoulder and was not certified in the pre-authorization process on March 7, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold therapy unit purchase and a cold therapy unit shoulder wrap for the right 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) Shoulder Chapter.

**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, Updated August 27, 2014.

**Decision rationale:** According to the Official Disability Guidelines, the use of continuous flow cryotherapy is recommended after surgery for up to seven days' time including home use. The use of continuous flow cryotherapy units has been proven to decrease pain, inflammation, swelling, and narcotic usage. However, as this request is for the purchase of a unit rather than just usage for seven days, this request for a cold therapy unit purchase and a cold therapy unit shoulder wrap for the right shoulder are not medically necessary.