

<b>Case Number:</b>	CM14-0040236		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	01/02/2014
<b>Decision Date:</b>	08/19/2014	<b>UR Denial Date:</b>	03/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in California. 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 male who reported an injury on 01/02/2014 due to a fall. On 01/28/2014, the injured worker presented with left shoulder and neck pain. Prior therapy included physical therapy, ice, medications, and the use of a sling. An examination of the left shoulder noted tenderness to the left shoulder, left trapezius and left supraspinatus muscle areas, left bicipital tendon, and left scapula. The range of motion values of the left shoulder were 180/180 for abduction, 180/180 for flexion, 60/60 for extension, internal rotation to T9, and 80/90 for external rotation. There was a positive Hawkins's sign and a positive Neer's test. The diagnoses were contusion of the left shoulder, sprain/strain of the unspecified site of the left shoulder and upper arm, and sprain of the neck. The provider recommended a cold therapy unit purchase for the left shoulder. The provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold therapy unit purchase for left shoulder for unspecified length of use:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 but 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 for more frequently treated acute injuries has not been fully evaluated. The guidelines recommend cryotherapy for up to 7 days post surgery. A cold therapy unit purchase would be indicated. As such, the request is not medically necessary.