

<b>Case Number:</b>	CM14-0063039		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	02/07/2014
<b>Decision Date:</b>	10/08/2014	<b>UR Denial Date:</b>	04/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 40 year old male who reported an injury on 02/07/2014. The mechanism of injury was due to pulling the starter rope on a stick edger and he heard a pop. The diagnoses included right shoulder strain and right shoulder impingement. Past treatments include medications, a sling and physical therapy. There were no diagnostic tests or surgical history provided. On 02/19/2014, the injured worker complained of right shoulder pain and weakness. The physical exam findings included no atrophy, severely reduced range of motion with flexion at 10 degrees, extension at 10 degrees, abduction at 40 degrees, internal/external rotation no more than 60 degrees, as well as tenderness to palpation on the right shoulder and mild tenderness over the right acromial joint. Medications included Ibuprofen 800mg. The treatment plan noted to take ibuprofen, complete home exercises, and attend physical therapy. The rationale for the request and request for authorization form were not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase heat/cold unit:** 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 (Acute & Chronic), Continuous-flow cryotherapy

**Decision rationale:** The request for purchase of heat/cold unit is not medically necessary. The injured worker has a history of right shoulder strain and right shoulder impingement. The Official Disability guidelines recommend continuous flow cryotherapy as an option after surgery, but not 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 on more frequently treated acute injuries including muscle strains and contusions has not been fully evaluated. The injured worker complained of right shoulder pain and weakness, however guidelines state the heat/cold unit is not recommended for nonsurgical treatment. There was no evidence of a surgical procedure noted. In addition, the submitted request does not specify the site of treatment. Furthermore, the request for the purchase of a unit exceeds the guideline recommendation of 7 days of use. Therefore, the request is not supported. As such, the request for purchase of heat/cold unit is not medically necessary.