

<b>Case Number:</b>	CM14-0069465		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	08/05/2010
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	04/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/14/2014

### 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 Management and is licensed to practice in Tennessee 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:

This is a 46-year-old female with a 8/5/10 date of injury. The mechanism of injury was not noted. According to a progress note dated 6/5/14, the patient was seen for a follow-up for right shoulder rotator cuff repair. Objective findings from right shoulder inspection include supraspinatus strength 4/5; abduction 100 degrees; extension 50 degrees; flexion 100 degrees; adduction 50 degrees; internal and external rotation 90 degrees; positive impingement with forward flexion, resisted abduction, and adduction/internal rotation. Diagnostic impression includes unspecified disorders of bursae and tendons in the shoulder region, and right shoulder impingement syndrome. Treatment to date includes medication management, as well as activity modification. A UR decision dated 4/25/14 denied the request for a 14-day rental of the continued passive motion machine. It is not necessary in individuals with simple rotator cuff repairs without evidence of contracture. Additionally, the cold therapy unit is only recommended for maximum of seven-days and not two weeks. The request for a sling to the right shoulder is recommended for certification as medically necessary and appropriate postoperatively.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**14- DAY RENTAL OF A CONTINUOUS PASSIVE MOTION (CPM), COLD THERAPY UNIT, NON-DISPENSED: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Shoulder Chapter.

**Decision rationale:** ODG Guidelines state that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. A UR decision dated 4/25/14 modified the request for a CPM cold therapy unit from a 14-day rental to a 7-day rental. Guidelines only support up to a 7-day use postoperatively. Therefore, the request is not medically necessary.