

<b>Case Number:</b>	CM14-0191931		
<b>Date Assigned:</b>	11/25/2014	<b>Date of Injury:</b>	03/12/2013
<b>Decision Date:</b>	01/12/2015	<b>UR Denial Date:</b>	11/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/17/2014

### 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, has a subspecialty in Interventional Spine 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 patient is a 44-year old female with an injury date on 03/12/2013. Based on the 11/04/2014 progress report provided by the treating physician, the diagnoses are: 1. Labral tear superiorly right shoulder. 2. Status post right shoulder arthroscopic subacromial decompression, March 5, 2014. 3. Biceps tendinitis with persistent symptoms and rotator cuff, MRI does not show a definite tear, but does show mild tendinosis of the rotator cuff tendons. According to this report, the patient complains of right shoulder and right thumb pain. The patient indicates that the pain level 5/10 and the quality of the pain are dull, aching, sharp, stabbing and burning. Pain is made worse by prolonged repetitive use, reaching behind the back, reaching overhead, and pushing and pulling. Range of motion of the right shoulder is: forward flexion 150, abduction 140, internal rotation 40, external rotation 90. Tenderness is noted at the right biceps tendon. O'Brien's test is positive. There were no other significant findings noted on this report. The utilization review denied the request for Durable medical equipment (DME): cold therapy unit, rental for 14 days on 11/10/2014 based on the ODG guidelines. The requesting physician provided treatment reports from 04/11/2014 to 11/04/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Durable medical equipment (DME): cold therapy unit, rental for 14 days: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**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 online for DME, Knee chapter under continuous-flow cryotherapy.

**Decision rationale:** According to the 11/04/2014 report, this patient presents with right shoulder and right thumb pain. The current request is for Durable medical equipment (DME): cold therapy unit, rental for 14 days but the treating physician's report containing the request is not included in the file. Regarding cold therapy, ODG guidelines recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." Review of reports show the patient is "status post right shoulder arthroscopic subacromial decompression on 03/05/2014. The use of Cold Therapy System appears reasonable; however the requested 14 days use exceed what is allowed per the guidelines. ODG supported the use of cold therapy up to 7 days. The request is not medically necessary.