

<b>Case Number:</b>	CM14-0208911		
<b>Date Assigned:</b>	12/22/2014	<b>Date of Injury:</b>	03/01/1999
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	11/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/15/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Minnesota, Florida  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 65 year old female, who sustained an industrial injury on 3/1/1999. She has reported multiple complaints. The diagnoses have included left shoulder dislocation, right knee meniscus tear, right hip injury, bilateral carpal tunnel syndrome, right trigger thumb, and bilateral thumb joint replacement. Treatment to date has included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and physical therapy. The medical records submitted for this review included an evaluation from May 6, 2014, and physical therapy treatment notes. On May 6, 2014, the IW complains of right shoulder pain. Physical examination documented tenderness over the subacromial and anterior aspect of bilateral shoulder, popping noted. The diagnoses included right scapular winging and right rotator cuff tendinitis. According to the Utilization Review letter dated 11/18/14, the most recent Magnetic Resonance Imaging (MRI), which was not available for this review, revealed a partial rotator cuff tear and surgery was therefore approved. On 11/18/2014 Utilization Review certified right shoulder arthroscopy with SAD and Biceps tend, assistant surgeon, post operative physical therapy for twelve (12) sessions for right shoulder, sling, and Norco 10/325mg #30. On 11/18/2014, Utilization Review non-certified a cold therapy unit for fourteen (14) days, noting the post operative treatment could be completed with ice packs. The MTUS, ACOEM and ODG Guidelines were cited. On 12/15/2014, the injured worker submitted an application for IMR for review of right shoulder arthroscopy with SAD and Biceps tend, assistant surgeon, post operative physical therapy for twelve (12) sessions for right shoulder, sling, cold therapy unit for fourteen day, and Norco 10/325mg #30.

## **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Associated surgical service: Cold therapy unit times 14 days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Continuous flow cryotherapy.

**Decision rationale:** ODG guidelines recommend continuous flow cryotherapy as an option after arthroscopy of the shoulder for 7 days. It reduces pain, swelling, inflammation, and need for narcotic medications after surgery. Use beyond 7 days is not recommended. The request as stated is for 14 days rental and as such, the medical necessity of the request has not been substantiated.