

<b>Case Number:</b>	CM15-0142233		
<b>Date Assigned:</b>	08/03/2015	<b>Date of Injury:</b>	08/03/2013
<b>Decision Date:</b>	09/03/2015	<b>UR Denial Date:</b>	06/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2015

### 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 56-year-old male, who sustained an industrial injury on 8-3-2013. The mechanism of injury is unknown. The injured worker was diagnosed as having acromioclavicular joint degenerative disease and rotator cuff syndrome. There is no record of a recent diagnostic study. Treatment to date has included injections and medication management. In a progress note dated 5-1-2015, the injured worker complains of acromioclavicular joint pain with elevation. Physical examination showed acromioclavicular joint tenderness and pain with range of motion. The treatment plan includes a left shoulder arthroscopy. The treating physician is requesting post-operative cold therapy unit purchase.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME-Post operative cold therapy unit purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, postoperative cold therapy unit.

**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:** California MTUS guidelines are silent on this issue. ODG guidelines are therefore used. ODG guidelines recommend continuous-flow cryotherapy for 7 days after shoulder surgery. It reduces pain, inflammation, swelling, and the need for narcotics after surgery. Use beyond 7 days is not recommended. The request as stated is for a cold therapy unit purchase, which is not supported by guidelines. As such, the medical necessity of the request has not been substantiated. This request is not medically necessary.