

<b>Case Number:</b>	CM15-0142529		
<b>Date Assigned:</b>	08/03/2015	<b>Date of Injury:</b>	04/15/2013
<b>Decision Date:</b>	09/03/2015	<b>UR Denial Date:</b>	06/26/2015
<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 57 year old male who sustained an industrial injury on 04-15-2013. Mechanism of injury was when an explosion occurred and he was thrown back landing right shoulder. Diagnoses include status post right shoulder surgery, right lateral epicondylitis-wrist forearm tendinitis, right carpal tunnel syndrome, cervical brachial syndrome, left shoulder impingement syndrome from favoring the right and left calcific tendinitis. Comorbid diagnosis is diabetes. Treatment to date has included diagnostic studies, medications, physical therapy, cortisone injections, exercise, activity modification, and status post right shoulder surgery on 06-23-2014. On 09/26/2014 a report of a Magnetic Resonance Imaging of the left shoulder revealed a full thickness tear of the supraspinatus with a large calcium deposit, tendinosis of the long head of the biceps, chronic degenerative labral tearing and moderate to severe acromioclavicular joint degenerative arthritis and subacromial space narrowing. He is temporarily disabled. His current medications include Ibuprofen, Naproxen, Hydrocodone-Acetaminophen, and Metformin. A physician progress note dated 06-17-2015 documents the injured worker has noted right shoulder improvement with therapy but left shoulder pain has been increasing over the preceding few weeks. He also complains of neck pain. The cervical spine is restricted and there is tenderness over the right posterior cervical triangle. Tinel's and Phalen's tests were positive in the right wrist. There is tenderness in the anterior right shoulder and motion was restricted. Impingement and abduction signs were positive. His left shoulder revealed tenderness and flexion was 150 degrees and abduction was 130 degrees with impingement and abduction signs being positive. The treatment plan includes associated surgical service: physical therapy two times a week for

six weeks, debridement calcific tendinitis, excision of distal clavicle, left shoulder arthroscopy, open biceps tenodesis, post-operative purchase of deluxe arm sling, pre-operative EKG, pre-operative labs-CBC, and CMP, rotator cuff repair, subacromial decompression, superior labrum anterior-posterior repair, and a surgical assistant. Treatment requested is for post-operative purchase of ice machine.

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

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

**Post-operative purchase of ice machine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**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 (ice machine) purchase which is not supported by guidelines. As such, the request is not medically necessary and has not been substantiated.