

<b>Case Number:</b>	CM15-0030204		
<b>Date Assigned:</b>	02/23/2015	<b>Date of Injury:</b>	02/22/2014
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	02/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 27 year old male, who sustained an industrial injury on February 22, 2014. He has reported tripping going upstairs, falling forward, with acute onset of left shoulder complaints. The diagnoses have included superior glenoid labrum lesion and shoulder pain. Treatment to date has included activity restrictions, physical therapy, and medications. Currently, the injured worker complains of severe pain located in the anterior and posterior aspect of the left shoulder, with significantly limited range of motion (ROM) and weakness. The Primary Treating Physician's report dated February 9, 2015, noted the injured worker had received 18 physical therapy visits, noted to have not helped at all, and in some instances made him worse. Physical examination was noted to show limited cervical spine range of motion (ROM), the left shoulder with a mildly tender bicipital groove, the acromioclavicular joint tender, and full wrist range of motion (ROM). A left shoulder x-ray was noted to show clavicular hookplate in place, with no fracture or arthritic changes. On February 12, 2015, Utilization Review non-certified a cold therapy unit rental for 7 days for the left shoulder, noting that the guidelines would not support a cryotherapy device was needed as need for operative intervention had not been established. The Official Disability Guidelines (ODG) was cited. On February 18, 2015, the injured worker submitted an application for IMR for review of a cold therapy unit rental for 7 days for the left shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold therapy unit rental for 7 days for the left shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers Compensation, 19th edition, 2014 Updates: Shoulder Chapter: Continuous-flow cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Shoulder, continuous flow-cryotherapy.

**Decision rationale:** MTUS Guidelines do not address this issue. ODG Guidelines address this issue in specific detail and recommend continuous flow cryotherapy only a limited time and only for post-operative use. The medical necessity of surgery has/had not been established at the time of the request. This leads to the conclusion that the medical necessity of the cold therapy unit rental is not established and is not medically necessary.