

<b>Case Number:</b>	CM15-0031976		
<b>Date Assigned:</b>	02/25/2015	<b>Date of Injury:</b>	08/28/2014
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	01/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/20/2015

### 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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 63 year old male who reported an injury on 08/28/2014. The mechanism of injury is described as a pulling motion. Diagnoses include adhesive capsulitis of the shoulder, 726.0, joint pain 719.41, and rotator cuff sprain/strain 840.4. Treatments have included therapy, activity modifications, and medication. A repeat arthroscopy, rotator cuff repair, acromioclavicular joint excision and subacromial decompression was recently certified. Diagnostics include an MRI performed 11/11/2014. Past surgical history includes a right shoulder arthroscopy with decompression, approximately 5 years remote. On the office visit of 01/13/2015, the injured worker complained of right shoulder pain and reduced range of motion, not adequately responsive to physical therapy and NSAIDS, VAS 3/10. Exam findings noted pain with active and resisted abduction. Medications include Xanax and NSAIDS. The request was for the purchase of a Don-Joy Iceman cryotherapy unit and pad for post-operative use as the patient was recently certified for a shoulder revision surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Don Joy Iceman and Pad, 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 (ODG) Shoulder Chapter, Continuous Cyrotherapy Device.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, revised 02/27/2015; continuous flow cryotherapy.

**Decision rationale:** The request was for a purchase of a DonJoy Iceman cold therapy unit and pad. The previous review gave a modified certification of a 7 day rental of these items, as per the recommended treatment guidelines that state postoperative use generally may be up to 7 days, including home use. The injured worker was certified for a shoulder revisions surgery. There are no extenuating circumstances presented to indicate a need to go beyond the recommended treatment guidelines. The request for purchase is not medically necessary.