

<b>Case Number:</b>	CM15-0059418		
<b>Date Assigned:</b>	04/03/2015	<b>Date of Injury:</b>	06/20/2014
<b>Decision Date:</b>	05/11/2015	<b>UR Denial Date:</b>	03/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/30/2015

### 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: Internal 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 47 year old male who sustained an industrial injury on June 20, 2014. He has reported injury to the right shoulder and has been diagnosed with persistent symptomatic traumatic slap tear, partial rotator cuff tear, impingement syndrome, and distal clavicle arthrosis, right shoulder. Treatment has included self-directed exercises, medications, and physical therapy. Currently the injured worker continued to have persistent moderate right shoulder pain exacerbated by activity. The treatment request included 30-day rental of cold therapy unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**30 day rental of cold therapy unit:** 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 Comp, 20th Edition, 2015 Updates: Shoulder Procedure.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) Continuous-flow cryotherapy, Cold compression therapy.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses physical modalities. American College of Occupational and Environmental Medicine (ACOEM) Chapter 9 Shoulder Complaints indicates that physical modalities are not supported by high-quality medical studies. Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) indicate that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. Cold compression therapy is not recommended in the shoulder, as there are no published studies. The initial comprehensive orthopedic consultation report dated 3/4/15 documented right shoulder superior labrum anterior and posterior SLAP tear, partial rotator cuff tear impingement syndrome, and distal clavicle arthrosis. A 30-day rental of cold therapy unit was requested. Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) indicate that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. The request for a 30-day rental exceeds ODG guideline recommendations. MTUS, ACOEM, and ODG guidelines do not support the request for a 30-day rental of cold therapy unit. Therefore, the request for 30-day rental of cold therapy unit is not medically necessary.