

<b>Case Number:</b>	CM15-0080271		
<b>Date Assigned:</b>	05/01/2015	<b>Date of Injury:</b>	02/01/2013
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	04/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/27/2015

### 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: 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 64-year-old female, who sustained an industrial injury on 2/1/13. The injured worker was diagnosed as having right shoulder pain and dysfunction, right shoulder partial thickness rotator cuff tear, left knee pain and mechanical symptoms, left knee chondromalacia, left knee lateral meniscus tear, right shoulder impingement, and right shoulder acromioclavicular joint arthrosis. Treatment to date has included right shoulder arthroscopy with intra-articular debridement of a partially torn rotator cuff on 3/19/15 and physical therapy. Currently, the injured worker complains of shoulder and knee pain. The treating physician requested authorization for a 30-day rental of a cold compression unit, purchase of wrap, ultra sling, and abduction arm support for the right shoulder.

### 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 Compression Unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Chapter 9, pages 195-220, Hot/cold therapy.

**Decision rationale:** The device provides cold compression therapy wrap for the patient's home for indication of pain, edema, and DVT prophylaxis for post-operative orthopedic patients. The patient underwent shoulder surgery. The provider has requested for this cold compression unit; however, has not submitted reports of any risk for deep venous thrombosis resulting from required non-ambulation, immobility, obesity or smoking factors. Rehabilitation to include mobility and exercise are recommended post-surgical procedures as a functional restoration approach recommended by the guidelines. MTUS Guidelines is silent on specific use of cold compression therapy, but does recommend standard cold pack for post exercise. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post-surgery; however, limits the use for 7-day post-operative period, as efficacy has not been proven after. The 330-Day Rental of Cold Compression Unit is not medically necessary and appropriate.