

<b>Case Number:</b>	CM14-0129297		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	11/02/2012
<b>Decision Date:</b>	10/28/2014	<b>UR Denial Date:</b>	08/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/14/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 54-year-old male with a reported date of injury on 11/02/2012. The mechanism of injury was not listed in the records. The injured worker's diagnoses included adhesive capsulitis of the right shoulder, bursitis, tendonitis of the right shoulder, and medial and lateral epicondylitis of the right shoulder. The injured worker's past treatments included pain medication, physical therapy, and surgical intervention. There was no relevant diagnostic imaging submitted for review. The injured worker's surgical history included right shoulder rotator cuff repair. The subjective complaints on 02/05/2014 included constant moderate pain that was described as burning to the right shoulder and intermediate to moderate pain that was described as throbbing to the right elbow. The patient also voiced carpal tunnel syndrome of constant moderate achy pain to the right wrist and hand. The objective physical exam findings noted 4+ muscle spasms, tenderness to the right rotator cuff muscles and the right upper shoulder muscles. The supraspinatus test was positive on the right. There were also 3+ spasms and tenderness to the right lateral and medial epicondyles. The Cozen's test was positive on the right elbow. The medication list was not documented in the note. The treatment plan was to continue physical therapy and for a postoperative cold therapy unit. A request was received for postoperative cold physical therapy unit for 14 day rental.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post Operative Cold Therapy Unit for 14 day rental: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265-266. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013. Carpal Tunnel Syndrome Chapter, Continuous cold therapy (CTT)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Cold compression therapy

**Decision rationale:** The request for post-operative cold therapy unit for 14 day rental is not medically necessary. The Official Disability Guidelines (ODG) state that cold compression therapy is not recommended in the shoulder, as there are no published studies to support its use in the shoulder. The injured worker is status post right shoulder rotator cuff repair. As a cold therapy unit is not supported for use in the shoulder, the request is also not supported by the evidence based guidelines. As such, the request is not medically necessary.