

<b>Case Number:</b>	CM14-0145740		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	12/12/2012
<b>Decision Date:</b>	10/28/2014	<b>UR Denial Date:</b>	08/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2014

### 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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 52-year-old male with a 12/12/12 date of injury, and arthroscopic rotator cuff repair, subacromial decompression, and Mumford procedure on 2/12/13. At the time (7/16/14) of request for authorization for Cold Therapy unit 30 day rental, left shoulder, there is documentation of subjective (left shoulder pain) and objective (restricted range of motion of the left shoulder) findings, current diagnoses (acromioclavicular joint sprain/strain, left shoulder impingement disorder, and rotator cuff sprain/strain), and treatment to date (physical therapy and medications (including ongoing treatment with Norco)). There is no documentation of a recent left shoulder surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold Therapy unit 30 day rental, left shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): 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 (ODG) Shoulder, Polar care (cold therapy unit)

**Decision rationale:** MTUS does not address this issue. ODG identifies that post-operative pain pump is not recommended and that there is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measure. Within the medical information available for review, there is documentation of diagnoses of acromioclavicular joint sprain/strain, left shoulder impingement disorder, and rotator cuff sprain/strain. However, despite documentation of status post arthroscopic rotator cuff repair, subacromial decompression, and Mumford procedure; and given documentation of a 2/12/13 date of surgery, there is no documentation of a recent left shoulder surgery. Therefore, based on guidelines and a review of the evidence, the request for Cold Therapy unit 30 day rental, left shoulder is not medically necessary.