

<b>Case Number:</b>	CM14-0161627		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	05/20/2010
<b>Decision Date:</b>	06/25/2015	<b>UR Denial Date:</b>	09/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2014

### 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. 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 (IW) is a 69 year old male who sustained an industrial injury on 05/20/2010. The report of the original injury is not available. The injured worker was diagnosed as having rotator cuff tear, right shoulder with impingement syndrome, and frozen shoulder, right shoulder with severe pain. Treatment to date has included physical therapy including ultrasound and therapeutic exercises, and medication of Protonix, Ultram and Voltaren. A MRI was done. Currently, the injured worker complains of pain and stiffness to the right shoulder with range of motion. The pain increases with overhead use. Examination showed pain and stiffness with right shoulder range of motion. There is point tenderness upon palpation about the acromioclavicular joint. Hawkins test is positive. Neer sign is positive. A MRI report of 08/13/2014 shows undersurface supraspinatus tendon tearing with moderate osteoarthritic changes to the glenohumeral and acromioclavicular joint. A right shoulder subacromial decompression with rotator cuff repair has been requested. A Request for authorization for rental of a cold unit postoperatively for the right shoulder seven to ten days is made.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Rental of a cold unit postoperatively for the right shoulder seven to ten days: Overturned**

**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 18th Edition 2013 updates Shoulder procedure- 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 (Acute & Chronic), Continuous-flow cryotherapy.

**Decision rationale:** The claimant sustained a work injury in May 2010. When seen, but he was having ongoing right shoulder pain and stiffness with increased pain with overhead use. Physical examination findings included decreased range of motion. Impingement testing was positive. Imaging results were reviewed. Authorization for a subacromial decompression and rotator cuff repair was requested. Continuous-flow cryotherapy is recommended as an option after surgery. Postoperative use generally may be up to 7 days including home use. In this case, the request is within the general guideline recommendation and is medically necessary.