

<b>Case Number:</b>	CM15-0114254		
<b>Date Assigned:</b>	06/22/2015	<b>Date of Injury:</b>	02/12/2015
<b>Decision Date:</b>	07/21/2015	<b>UR Denial Date:</b>	06/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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, Indiana, Oregon  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 42 year old, male who sustained a work related injury on 2/12/15. The diagnoses have included left shoulder partial thickness rotator cuff tear, labral fraying and impingement with acromioclavicular joint degeneration. Treatments have included physical therapy, left shoulder cortisone injection and medications. In the PR-2 dated 5/19/15, the injured worker complains of left shoulder pain. He has a positive impingement sign to internal rotation of left shoulder. He is having difficulty raising left shoulder. He has tenderness over the acromioclavicular joint. He has a positive O'Brien's test with signs of labral pathology. The treatment plan includes a request for authorization for left shoulder surgery to include request for a cold therapy unit for postoperative use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold therapy unit, Left Shoulder, Purchase: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder - 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.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for up to 7 days. However the DME definition in the same section states that DME is durable and could normally be rented and used by successive patients. Based on the above, the request for the purchase is not medically necessary.