

<b>Case Number:</b>	CM15-0073971		
<b>Date Assigned:</b>	04/24/2015	<b>Date of Injury:</b>	10/05/2012
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	04/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/17/2015

### 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: Preventive Medicine, Occupational Medicine

### 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 47-year-old male who sustained an industrial injury on 10/5/12 while performing an overhead activity resulting in acute onset of right shoulder pain. The pain gradually increased and was refractory to corticosteroid injection. He currently complains of right shoulder pain that is limiting his daily functional activity. He also has left shoulder pain and weakness. Diagnoses include left shoulder pain, status post arthroscopic rotator cuff repair; right shoulder impingement syndrome. Treatments to date include anti-inflammatory, activity modification, and physical therapy. Diagnostics include MRI of the right shoulder (3/17/15) with mild rotator cuff tendinitis and acromioclavicular joint arthrosis. In the request for authorization dated 4/2/15 the treating provider requested cold therapy unit X 14 day rental due to the supraspinatus tear.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold therapy x14 day rental:** 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 cyrotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic), Cold/heat packs.

**Decision rationale:** According to the Official Disability Guidelines, there is minimal evidence supporting the use of cold therapy except in the acute phase of an injury or for the first seven days postoperatively. A cryotherapy unit will sometimes be approved for up to seven days following a surgical procedure, but cold packs are as effective. The original reviewer approved a modified request to a 7-day rental rather than 14 days. Cold therapy x14 day rental is not medically necessary.