

Case Number:	CM13-0004875		
Date Assigned:	01/15/2014	Date of Injury:	04/15/2011
Decision Date:	03/19/2014	UR Denial Date:	07/25/2013
Priority:	Standard	Application Received:	07/31/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation 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 physician 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:

This is a male patient with a date of injury of April 15, 2011. A utilization review determination dated July 25, 2013 recommends noncertification of intermittent limb compression cold therapy device. A progress report dated December 13, 2013 identifies the subject of complaints indicating that the patient sustained a rotator cuff injury with subsequent surgical intervention of the left rotator cuff. The patient currently complains of escalating pain in the left shoulder. And MRI shows a considerable tear. The patient is currently taking medication for pain control. Physical examination identifies reduced shoulder range of motion with considerable weakness of the left shoulder. Diagnoses include "status post left shoulder surgery X2 with considerable dysfunction remaining. He is a candidate for another surgical procedure." Current treatment plan recommends total shoulder arthroplasty. An operative report dated September 19, 2012 indicates that the patient underwent left shoulder arthroscopy with rotator cuff repair, SLAP repair, and subacromial decompression and acromioplasty.

IMR ISSUES, DECISIONS AND RATIONALES

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

retrospective request for 1 intermittent Limb Compression Cold Therapy Device, 21 days:
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 (Acute & Chronic)

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

Decision rationale: Regarding the request for intermittent limb compression cold therapy device, California MTUS and ACOEM do not contain criteria related to that request. Official Disability Guidelines (ODG) states that cold compression therapy is not recommended for the shoulder as there are no published studies. As such, the currently requested limb compression cold therapy device is not medically necessary.