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| Case Number: | CM13-0009939 | | |
| Date Assigned: | 09/20/2013 | Date of Injury: | 02/01/2010 |
| Decision Date: | 02/11/2014 | UR Denial Date: | 08/08/2013 |
| Priority: | Standard | Application Received: | 08/12/2013 |

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 & Rehabilitation, and is licensed to practice in Oklahoma and Texas. 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:

The patient is a 55-year-old female who reported an injury on 02/01/2010. The mechanism of injury was continuous trauma related to job duties. The official complaints included difficulty flexing and extending her wrist, grasping and lifting objects, and radiation of pain from her shoulder and neck to the upper extremities. She is reported to have had unspecified neurologic studies performed on an unspecified date with negative results for nerve compression. The patient had a magnetic resonance imaging (MRI) of the right elbow on 04/29/2011 that revealed a partial thickness tear of the common extensor tendon and mild chondromalacia of the radial head with small joint effusion. The patient also had an unofficial cervical spine MRI that revealed moderate degenerative changes, most prominent in C4 through C6, neural foraminal narrowing at C3-4, C4-5, and C5-6. The patient received an unknown duration of physical therapy, Cortisone injections, and medications, all with minimal benefit. She then received a right elbow fasciectomy and ostectomy on 06/10/2011 with improvement noted. The patient continued to have neck and shoulder complaints and was noted to have a positive impingement and cross over impingement sign on the right shoulder, with full range of motion in all planes. The patient is known to have had an MRI of the right shoulder that was positive for a rotator cuff tear; the report was not included in the medical records. The patient received an arthroscopic SAD (Shoulder Arthroscopic Decompression) and rotator cuff repair on 01/19/2012. She received at least 16 sessions of physical therapy postoperatively with no exceptional factors noted in the clinical records. Despite surgical interventions, the patient continued to have right shoulder pain and persistent significant neck pain. The patient developed left shoulder pain in 07/2012, and an MRI done on 07/27/2012 reported a full thickness rotator cuff tendon tear, partial tear of the subscapularis te

IMR ISSUES, DECISIONS AND RATIONALES

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

Rental of Cold Therapy Unit x 30 days for shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

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

Decision rationale: The California MTUS/ACOEM Guidelines did not specifically address the use of a cold therapy unit; therefore, the Official Disability Guidelines (ODG) were supplemented. The ODG recommends continuous flow cryotherapy as an option after surgery, but generally only for use up to 7 days postoperatively. As the current request is for 30 days, it exceeds Guideline recommendations. As such, the request for Rental of Cold Therapy Unit x 30 days for shoulder is non-certified.