

Case Number:	CM13-0055403		
Date Assigned:	06/09/2014	Date of Injury:	06/27/2012
Decision Date:	10/30/2014	UR Denial Date:	11/11/2013
Priority:	Standard	Application Received:	11/21/2013

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. The expert reviewer is Board Certified in Orthopaedic Surgery 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 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/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 47-year-old male sustained an industrial injury on 6/27/12. The mechanism of injury was not documented. Past surgical history was positive for a revision arthroscopic rotator cuff repair with mini-open biceps tenodesis on 3/6/13. The 8/15/13 right shoulder MRI impression documented that the majority of the supraspinatus tendon was torn with retraction of fibers. The tear also involved some of the anterior fibers of the infraspinatus tendon. There was a small interstitial tear of the subscapularis tendon. There was mild fatty atrophy of the supraspinatus and infraspinatus tendons and acromioclavicular joint degenerative changes. The patient underwent right shoulder revision arthroscopic rotator cuff repair, subacromial decompression, and debridement of posterior superior labral tear on 11/6/13. A request was submitted for a cold therapy unit for 21 days use. The 11/11/13 utilization review decision modified a request for cold therapy unit rental for 21 days to 7 days consistent with guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy unit x 21 days - Right Shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 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, Continuous flow cryotherapy

Decision rationale: The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous flow cryotherapy is an option for up to 7 days in the post-operative setting following shoulder surgery. The 11/11/13 utilization review decision recommended partial certification of a cold therapy unit for 7-day rental. There is no compelling reason in the records reviewed to support the medical necessity of a cold therapy unit beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.