

Case Number:	CM14-0157959		
Date Assigned:	10/01/2014	Date of Injury:	09/11/2013
Decision Date:	12/31/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	09/26/2014

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 Family Medicine 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 is a 51 year old male patient who sustained a work related injury on 9/11/13. Patient sustained the injury when he was lifting some very heavy pipes weighing 40,000 pounds with a crane-type device; the pipe hit his shoulder knocking his arm suddenly in the abducted externally rotated position. The current diagnoses include left shoulder pain and left shoulder rotator cuff repair on 04/08/14. Per the doctor's note dated 7/9/14, patient has complaints of left shoulder pain. Physical examination revealed limited range of motion in flexion, external rotation, and internal rotation. The current medication lists include Naprosyn and Norco. The patient has had MRI of the left shoulder on 11/1/13 that revealed a full thickness tear of the supraspinatus tendon and the anterior portion of the infraspinatus tendon and X-ray of the left shoulder on 3/24/14 that revealed degenerative changes. The patient's surgical history include left shoulder rotator cuff repair on 04/08/14. The patient has received an unspecified number of the physical therapy visits for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold compression unit times 30 day rental DOS 07/29/14: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

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: Per the cited guidelines regarding cold therapy, "In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage." In addition per the ODG, continuous-flow cryotherapy is "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." Any recent detailed clinical evaluation note of the treating physician documenting significant functional deficits that would require a Cold Compression Unit times 30 day rental was not specified in the records provided. The patient's surgical history include left shoulder rotator cuff repair on 04/08/14. The cited guidelines recommend use of cold therapy unit for 7 days post operatively. The rationale for use of Cold Compression Unit 3 months after the surgery was not specified in the records provided. The details of the post op therapy were not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. The response of the symptoms to a period of rest, oral pharmacotherapy and splint is not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The medical necessity of the request for Cold Compression Unit times 30 day rental DOS 07/29/14 is not fully established in this patient.

Compression Wrap (Purchase) DOS 07/29/14: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

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 medical necessity of the cold compression unit rental on DOS 7/29/14, was not fully established, therefore the medical necessity of the compression wrap purchase that goes with the compression unit was also not fully established.