

Case Number:	CM14-0158850		
Date Assigned:	10/02/2014	Date of Injury:	04/27/2010
Decision Date:	11/19/2014	UR Denial Date:	08/21/2014
Priority:	Standard	Application Received:	09/29/2014

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 Orthopedic 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 57-year-old male truck driver sustained an industrial injury on 4/27/10. Injury occurred when a utility truck was backed up under a trailer and hit him on his right side. Past surgical history was positive for cervical spine fusion and two right shoulder arthroscopic surgeries. The 3/11/14 right shoulder MR arthrogram impression documented subscapularis tendinosis with moderate grade partial thickness articular surface/interstitial tearing, very low-grade partial thickness tearing of the distal infraspinatus tendon insertion, and mild supraspinatus tendinosis. There was no full thickness rotator cuff tear or retraction. There was mild irregularity of the articular surface of the superior labrum with contrast extension along the chondrolabral junction likely related to a combination of post-surgical changes and a small non-displaced SLAP tear/re-tear. There was mild fraying and blunting of the anterior superior/anterior inferior labrum possibly related to post-operative changes or mild chronic degenerative changes. There was mild osteophyte formation along the anterior and posterior glenoid. The 7/22/14 orthopedic report cited severe neck pain and popping, and right shoulder pain and swelling. Cervical spine exam documented painful and decreased range of motion, right C5/6 radiculopathy, spasms and tenderness over the cervicotracheal ridge. Right shoulder exam documented painful range of motion, flexion and abduction to 90 degrees, and global right shoulder tenderness. The diagnosis was cervical degenerative disc disease, spondylosis C4-C7, status post cervical fusion, and status post right shoulder surgery. The treatment plan recommended right shoulder open decompression and rotator cuff repair, cold therapy unit for the right shoulder, and continued medications: Zanaflex, Tylenol #3, and Celebrex. The 8/21/14 utilization review denied the request for a motorized cold therapy unit as the associated right shoulder surgery request was not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized Cold Therapy Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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

Decision rationale: The California MTUS are silent regarding cold therapy units. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery, but not for non-surgical treatment. Postoperative use is typically supported for up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect of non-surgical treatment has not been fully evaluated. The use of a cold therapy unit would be reasonable for 7 days post-operatively if the right shoulder surgery is certified. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request is not medically necessary.