

Case Number:	CM14-0022498		
Date Assigned:	05/09/2014	Date of Injury:	05/24/2011
Decision Date:	07/10/2014	UR Denial Date:	02/17/2014
Priority:	Standard	Application Received:	02/21/2014

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 Physical Medicine & Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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:

The injured worker is a 46-year-old female who reported an injury on 05/24/2011 secondary to an unknown mechanism of injury. Her diagnoses include right shoulder full thickness rotator cuff tear with residual loss of motion and weakness. The injured worker was evaluated on 01/28/2014 and reported 8/10 right shoulder pain. On physical examination, she was noted to have tenderness to palpation of the right acromioclavicular joint, a positive impingement sign on the right, and painful range of motion. The injured worker was recommended for a right shoulder abduction pillow sling, Vicodin, Motrin, continued home exercise, and home health. A request for authorization for a right shoulder rotator cuff repair surgery was also submitted. Within that request, there was a request for preapproval of a cold compression therapy system for 3 weeks postoperatively. The injured worker underwent a right shoulder repair of a full thickness rotator cuff tear and a subacromial decompression on 02/03/2014 according to the operative report provided. The documentation submitted for review failed to provide a request for authorization form.

IMR ISSUES, DECISIONS AND RATIONALES

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

PNEUMATIC COLD COMPRESSION WITH SHOULDER WRAP: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints.

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, Continuous-flow cryotherapy.

Decision rationale: The Official Disability Guidelines may recommend continuous flow cryotherapy as an option after surgery for use up to 7 days postoperatively. The injured worker underwent a right shoulder rotator cuff repair and subacromial decompression on 02/03/2014. The medical records submitted for review indicated that a cryotherapy unit would be used for 3 weeks postoperatively, which is excessive according to the evidence based guidelines for post-operative treatment duration. There are no exceptional factors documented to indicate that the injured worker would benefit from cryotherapy beyond 7 days in the postoperative treatment period. Furthermore, the request as written is for the purchase of durable medical equipment. There is no documented rationale to indicate the necessity for the purchase of a cold compression therapy system as opposed to rental. Therefore, based on the guidelines for treatment duration with cryotherapy, the necessity for purchase of a cold compression therapy unit for use of 3 weeks postoperatively has not been established. As such, the request for a pneumatic cold compression with shoulder wrap is not medically necessary and appropriate.