

Case Number:	CM14-0024817		
Date Assigned:	06/13/2014	Date of Injury:	11/09/2011
Decision Date:	07/15/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	02/27/2014

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 and Rehabilitation and Pain Management, has a subspecialty in Interventional Spine 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:

The patient is a 45 year old with an injury date on 11/9/11. Based on the 2/10/14 progress report provided by [REDACTED] the diagnoses are: 1. Left rotator cuff impingement and AC joint arthrosis. 2. Obesity. Exam on 2/10/14 showed "symmetrical shoulder without atrophy. Left shoulder range of motion is 180/90/80 with tenderness to palpation at AC joint and positive impingement sign. Pain with abduction strength testing." [REDACTED] is requesting durable medical equipment (cold therapy unit). The utilization review determination being challenged is dated 2/18/14 and modifies purchase of cold therapy unit to a 7 day rental. [REDACTED] is the requesting provider, and he provided treatment reports from 7/30/13 to 2/10/14 .

IMR ISSUES, DECISIONS AND RATIONALES

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

DURABLE MEDICAL EQUIPMENT MI (COLD THERAPY UNIT): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: This patient presents with increased left shoulder pain with stiffness/popping. The treating physician has asked durable medical equipment (cold therapy unit) on 2/11/14, and RFA includes request for a left shoulder acromioplasty. The 2/10/14 report shows patient has been using home exercise, Motrin, and ice without success. 6 cortisone injections to left shoulder and physical therapy had no positive effect per 12/26/13 report. Patient has no recent history of surgeries. Regarding cryotherapy, ODG allows for short-term post-operative use, 7 days following shoulder surgery. ODG states that no research shows any additional added benefit for more complicated cryotherapy units over conventional ice bags or packs. In this case, cryotherapy is indicated for patient's future shoulder surgery. ODG does not support use of more complicated cryotherapy units over conventional ice packs. In addition, ODG recommends only 7 day post-op use and request is for purchase of cold therapy unit. The request is not medically necessary and appropriate.