

Case Number:	CM14-0030992		
Date Assigned:	06/20/2014	Date of Injury:	08/09/2012
Decision Date:	09/26/2014	UR Denial Date:	03/04/2014
Priority:	Standard	Application Received:	03/11/2014

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 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 49 year old male who reported an injury on 08/09/2012 while trying to catch something as it was falling. The injured worker had diagnoses of adhesive capsulitis shoulder, left rotator partial-thickness rotator cuff tear, left shoulder subacromial impingement syndrome, and frozen shoulder. Past treatment included medications, joint injection, physical therapy, and a home exercise program. Diagnostic testing included an MRI of the left upper extremity on 11/30/2012 and x-rays on 10/25/2012. The injured worker underwent left shoulder manipulation under anesthesia on 09/11/2013. The clinical note dated 03/26/2014 noted the injured worker complained of dull, sharp, burning pain to left shoulder rated 5/10, with some numbness and tingling associated with it. Physical examination of the left shoulder revealed range of motion demonstrated forward flexion to 160 degrees, with significant scapulothoracic motion, abduction was 90 degrees, external rotation was 80 degrees at 70 degrees of abduction, internal rotation was 40 degrees, extension was 50 degrees, adduction was 30 degrees, and external rotation at the side was 20 degrees. The injured worker's medications were not provided. The treatment plan was for contrast compression therapy device. The rationale for the request was not provided. The request for authorization form was submitted on 04/07/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Contrast compression therapy device: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers Comp, chapter shoulder, Surgery for adhesive capsulitis Official Disability Guidelines, Treatment in Workers Comp, chapter shoulder, Surgery for impingement Official Disability Guidelines, Treatment in Workers Comp, chapter shoulder, Mumford procedure.

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

Decision rationale: The request for contrast compression therapy is not medically necessary. The injured worker has a diagnosis of adhesive capsulitis shoulder. The Official Disability Guidelines (ODG) state contrast compression therapy device is not recommended in the shoulder, as there are no published studies. The guidelines recommend the use of continuous flow cryotherapy without compression for up to 7 days post-operatively. There is a lack of documentation indicating the injured worker is schedule to undergo surgery in the near future or has recently undergone surgery. Additionally, the guidelines do not recommend the use of cold compression therapy for the shoulder. The site at which the unit is to be used and the duration of treatment are not indicated. As such, the request exceeds the recommendations, therefore the request for cold compression unit is not medically necessary.