

Case Number:	CM14-0032715		
Date Assigned:	06/20/2014	Date of Injury:	08/26/2013
Decision Date:	07/18/2014	UR Denial Date:	02/22/2014
Priority:	Standard	Application Received:	03/14/2014

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 is licensed to practice in Nevada. 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 53-year-old male injured on 8/26/2013. The mechanism of injury was noted as lifting/pulling injury sustained at work. The most recent progress note, dated 1/15/2014, an orthopedic consultant indicated that there were ongoing complaints of right shoulder pain. The physical examination demonstrated right Shoulder, no bruising or swelling, no signs of muscle atrophy and no evidence of scapular winging. Range of motion was forward flexion 130, abduction 120, external rotation 30 and internal rotation to L-5. Motor and sensory examination was grossly intact. Radial pulse is 2+. No evidence of shoulder instability and positive impingement, Diagnostic imaging studies included an x-ray of the right shoulder taken on 10/15/2003, which revealed glenohumeral arthritis on the right side. MRI of the right shoulder, dated 9/30/2013, revealed advanced arthritic changes of the glenohumeral joint and evidence of joint effusion. Rotator cuff was intact with inflammation. No evidence of a full thickness tear of the rotator cuff. Acromioclavicular joint arthritic changes, degenerative changes of the labrum. Previous treatment included physical therapy and ibuprofen. A request had been made for purchase of post-operative cold therapy unit for the right shoulder and was not certified in the pre-authorization process on 2/22/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of Post Operative Cold Therapy unit for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10,27. Decision based on Non-MTUS Citation Official Disability Guidelines,continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): ODG -TWC: Shoulder (Acute & Chronic); (updated 04/25/14) - Continuous Flow Cryotherapy.

Decision rationale: Post-operative cold therapy units are recommended as an option after surgery but not for nonsurgical treatment. Post-operative use generally may be 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 pain usage. However, the effect on more frequently treated acute injuries (e.g.-muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. According to the medical records reviewed for this 58 year-old male who sustained a work related right shoulder injury, he was recommended for surgical intervention. His surgery was not approved. Thus, he is not a candidate for the continuous flow cryotherapy unit. This request is deemed to be not medically necessary.