

Case Number:	CM14-0037305		
Date Assigned:	06/25/2014	Date of Injury:	01/13/2011
Decision Date:	09/05/2014	UR Denial Date:	03/07/2014
Priority:	Standard	Application Received:	03/27/2014

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, has a subspecialty in Pain Management 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 is a patient with a date of injury of January 13, 2011. A utilization review determination dated March 7, 2014 recommends modified certification for the request of a cold therapy unit. The determination recommended modification of the cold therapy unit to 7 days, for postoperative use of following right shoulder arthroscopy. A progress report dated July 22, 2013 identifies diagnoses including bilateral shoulder internal derangement. The treatment plan indicate that the patient is pending left shoulder arthroscopic surgery. A progress report dated January 7, 2014 identifies subjective complaints of bilateral shoulder pain. The note indicates that the patient continues with a home exercise program and anti-inflammatory medication. Objective examination findings reveal reduced range of motion in the left and right shoulders with tenderness the palpation over the supraspinatus tendons and acromioclavicular joints. Diagnoses include impingement syndrome of shoulders bilaterally, subacromial bursitis bilaterally, and rotator cuff tear bilaterally. The treatment plan requests authorization for shoulder arthroscopic evaluation and surgery was possible rotator cuff repair.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 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), Shoulder Chapter, Continuous-flow cryotherapy section.

Decision rationale: Regarding the request for Cold Therapy Unit, ODG cites that continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use, but not for non-surgical treatment. Within the documentation available for review, it appears the unit was intended for post-surgical therapy for the shoulder. The current request does not have a duration specified. Guidelines do not support the open-ended application of cold therapy units for the shoulder, and recommend a maximum of 7-days use. As such, the currently requested Cold Therapy Unit is not medically necessary.