MAXIMUS Federal Services

Case Number:	CM14-0043005		
Date Assigned:	06/30/2014	Date of Injury:	08/06/2012
Decision Date:	09/25/2014	UR Denial Date:	03/28/2014
Priority:	Standard	Application Received:	04/09/2014

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 Family Medicine 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 44 year old male patinet who reported an industrial injury to the shoulder on 8/6/2012, over two (2) years ago, attributed to the performance of his job tasks as a helicopter mechanic. The patient underwent conservative treatment to the shoulder and was subsequently recommended sugical intervention to the shoulder. The patient was to have surgical intervention with a shoulder biceps tenodesis with debridement. The treatment plan included the DME rental of a cold unit for 21 days and the purchase of a cold wrap.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Compression Unit (21 Day Rental): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) wrist, forearm, hand chapter and low back chapter-- cold/heat packs; heat therapy.

Decision rationale: The request for the motorized cold unit is not supported with objective evidence that demonstrates medical necessity and is inconsistent with the recommendations of the CA MTUS for the treatment of postoperative pain to the shoulder s/p arthroscopy. There is

no demonstrated medical necessity for the Cold Therapy unit over the recommended cold packs. The requested DME is inconsistent with evidence-based guidelines and not medically necessary for the rehabilitation of the left shoulder, as there is only an evidence-based guidelines recommendation of seven (7) days use of a postoperative cold circulation unit for home use. There are many alternatives available for the application of cold to the shoulder.The request for the cold therapy unit for home use post operatively is not supported with objective evidence that demonstrates medical necessity and is inconsistent with the recommendations of the CA MTUS for the treatment of the postoperative shoulder for the requested 21 days. There is no demonstrated medical necessity for the Motorized hot/cold unit over the recommended cold packs or hot packs. The motorized hot/cold unit is not demonstrated to be medically necessary for prolonged home use post operatively. The California MTUS recommends up to seven (7) days of cold therapy status post arthroscopy. Therefore, the request for a 21-day rental of the cold circulation unit is not medically necessary.

Cold Compression Wrap: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) wrist, forearm, hand chapter and low back chapter-- cold/heat packs; heat therapy.

Decision rationale: The cold pad for the postoperative treatment of the shoulder is medically necessary for the recommended seven (7) days of home therapy. The use of the cold compression wrap is necessary for the use of the cold unit directed to the postoperative shoulder. The wrap is cannot be rented and is consumable DME. The purchase of the cold wrap would be necessary if the patient received a seven-day rental or a 21-day rental of the cold unit. Therefore, the purchase of the cold compression wrap is medically necessary.