

Case Number:	CM14-0049087		
Date Assigned:	06/25/2014	Date of Injury:	01/02/2014
Decision Date:	07/23/2014	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	03/26/2014

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 Orthopaedic Surgery 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 50-year-old female sustained an industrial injury 1/2/14, relative to repetitive lifting heavy boxes overhead. The 2/26/14 left shoulder MRI documented a type II acromion, with a likely supraspinatus partial thickness tear and high-grade infraspinatus partial thickness tear. Findings included calcific tendinitis, mild to moderate supraspinatus atrophy, circumferential labral degeneration, biceps tendinosis, and cortical irregularity of the greater tuberosity. The 2/28/13 treating physician report documented left shoulder pain and numbness. Physical exam findings documented 130 degrees flexion with significant pain starting at 85 degrees. External rotation was 45 degrees with internal rotation to T11. Extension rotation strength was 4/5, and the supraspinatus strength was 3/5. There was severe pain with impingement testing. The treating physician stated the MRI showed near full-thickness rotator cuff tear, left shoulder arthroscopy with rotator cuff repair, possible tenodesis, and labral debridement. A subacromial decompression was recommended. A post-operative cooling unit was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cooling Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 555-556. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, 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, Continuous flow cryotherapy.

Decision rationale: The California MTUS Guidelines are silent regarding cold therapy devices. The Official Disability Guidelines (ODG) recommends continuous flow cryotherapy as an option after surgery. Postoperative 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 usage. There is no compelling reason in the records reviewed to support the medical necessity of a cooling unit beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request for a cooling unit is not medically necessary.