

Case Number:	CM14-0049959		
Date Assigned:	07/07/2014	Date of Injury:	06/26/2012
Decision Date:	08/28/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	04/17/2014

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 Occupational 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:

The patient is a 32-year-old male who has submitted a claim for disorders of the bursae and tendons in the shoulder region, associated with an industrial injury date of 06/26/2012. Medical records from 09/16/2013 to 08/04/2014 were reviewed and showed that the patient complained of left shoulder pain graded at 8/10. Physical examination of the left shoulder revealed tenderness over the biceps and greater tuberosity. Limited internal and external rotation was noted. Supraspinatus, infraspinatus, and subscapularis strength was 4+/5. O'Brien and Speed tests were positive. Treatment to date has included Lidocaine injection (11/26/2013), Medrol Dosepak, and physical therapy. Utilization review dated 04/11/2014 denied the request for the purchase or rental of a cold unit therapy unit for the left shoulder, for 7 day use post-up because the medical necessity could not be established, as surgery was denied as well.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase or rental of a cold therapy unit for the left shoulder for 7 day use post-op: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

Decision rationale: The Aetna Clinical Policy Bulletin considers passive cold compression therapy units experimental and investigational for all other indications, because their effectiveness for use has not been established. The use of hot/ice machines and similar devices are experimental and investigational for reducing pain and swelling after surgery or injury. Studies failed to show that these devices offer any benefit over standard cryotherapy with ice bags/packs. In this case, the request for a cold therapy unit was for post-operative use. However, the request for surgery was deemed not medically necessary (04/10/2014). Therefore, the request is also not medically necessary.