

Case Number:	CM14-0052585		
Date Assigned:	07/07/2014	Date of Injury:	06/06/2013
Decision Date:	08/22/2014	UR Denial Date:	04/09/2014
Priority:	Standard	Application Received:	04/21/2014

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 Hawaii and 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 29-year-old male with a date of injury on 6/6/2013. A review of the medical records indicate the patient is undergoing treatment for right shoulder strain and cervical strain. Subjective complaints (3/5/2014) include intermittent moderate to severe right shoulder pain with painful popping sensation that worsens with pulling/lifting/sleeping. Objective findings (3/5/2014) include increased tone and tenderness to paracervical/trapezius muscles, decreased right shoulder range of motion with positive apprehension test and negative impingement sign. Treatment has included physical therapy (unknown number of sessions), right shoulder arthroscopy, naproxen 550mg, omeprazole 20mg, cyclobenzaprine 10mg, and tramadol 50mg. The patient was approved for right shoulder arthroscopy (date of procedure is unknown). A utilization review dated 4/9/2014 modified a request for post-operative cold therapy unit for 7 days (original request was for Water Circ Cold Pad with Pump with time limit) due to guidelines recommended time limit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Water Circ Cold Pad with Pump: Upheld

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

Decision rationale: MTUS and ACOEM are silent regarding this topic. ODG states, Recommended as an option after surgery, but not for nonsurgical treatment. 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; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. The patient was approved for right shoulder arthroscopy, but the date of procedure is unknown. Progress notes and request for authorization does not detail the length of time for the cold therapy unit. A 7 day post-operative time period is reasonable and within guidelines. The treating physician does not include additional information that would justify the use of a cold therapy unit in excess of the guideline recommendation. As such, the request for Water Circ Cold Pad with Pump is not medically necessary.