

Case Number:	CM14-0077396		
Date Assigned:	07/18/2014	Date of Injury:	03/10/2014
Decision Date:	09/22/2014	UR Denial Date:	05/12/2014
Priority:	Standard	Application Received:	05/27/2014

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 and is licensed to practice in Texas, and Ohio. 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 injured worker is a 55-year-old female with a reported date of injury on 03/10/2014. The mechanism of injury was noted to be a motor vehicle accident. Her diagnoses were noted to include impingement syndrome, near full thickness rotator cuff tear, gradual development of adhesive capsulitis, subacromial bursitis, and mild to moderate acromial clavicular degenerative joint disease. Her previous treatments were noted to include medications. The progress note dated 04/28/2014 revealed the injured worker complained of left shoulder pain, rated 8/10. A physical examination of the left shoulder revealed tenderness to palpation at the anterolateral capsule/rotator cuff. The range of motion to the left shoulder was within full limits and weakness was noted with the isolated rotator cuff testing. The motor strength testing to the left shoulder was noted to be rated 5/5. The special test noted strongly positive signs of irritation during impingement maneuvers. The Request for Authorization form dated 05/05/2014 was for a cold therapy unit for purchase for the left shoulder; however, the provider's rationale was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit for purchase for the left shoulder: 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, updated 4/25/14, Continuous flow therapy.

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 injured worker was waiting for authorization for left shoulder surgery. The Official Disability Guidelines recommend continuous flow cryotherapy 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, such as muscle strains and contusions, have not been fully evaluated. Continuous flow cryotherapy units provide regulated temperatures through the use of power to circulate ice water in the cooling packs. The guidelines recommend rental of the cold therapy units for up to 7 days. Therefore, the request for a purchase of a cold therapy is not appropriate. Therefore, the request is not medically necessary.

Cold therapy unit x7 day rental for the left shoulder: 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, updated 4/25/14, Continuous flow therapy.

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 injured worker was waiting for authorization for left shoulder surgery. The Official Disability Guidelines recommend continuous flow cryotherapy 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, such as muscle strains and contusions, have not been fully evaluated. Continuous flow cryotherapy units provide regulated temperatures through the use of power to circulate ice water in the cooling packs. The guidelines recommend rental of the cold therapy units for up to 7 days, however, there is a lack of documentation of the injured worker having been approved for surgery to warrant a cold therapy unit. Therefore, the request is not medically necessary.