MAXIMUS Federal Services

Case Number:	CM14-0094885		
Date Assigned:	07/25/2014	Date of Injury:	10/03/2011
Decision Date:	09/29/2014	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	06/23/2014

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 Illinois. 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 40-year-old male who reported an injury on 10/03/2011 while pulling on springs. On 03/04/2014, the injured worker presented with bilateral shoulder pain. Upon examination of the left shoulder, there was painful limited range of motion, tenderness over the subacromial arch, and a positive impingement test. The diagnoses were shoulder pain and rotator cuff tendinopathy. Diagnostic studies revealed a right shoulder rotator cuff tendinopathy, left shoulder rotator cuff tendinopathy, partial thickness rotator cuff tear, chronic low back pain, degenerative disc disease of the lumbar spine involving primarily L3-4 and L4-5, and degenerative disc disease of the cervical spine involving primarily the C5-6. The current treatment plan included a left shoulder arthroscopy, subacromial decompression, and debridement versus repair of the rotator cuff. The provider recommended a cold therapy unit rental for the left shoulder x7 days. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy Unit Rental for Left Shoulder x 7 Days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Table 9-6,Chronic Pain Treatment Guidelines Shoulder Complaints. 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 request for a cold therapy unit rental for the left shoulder x7 days is not medically necessary. 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 has not been fully evaluated. The injured worker's plan of care revealed a left shoulder arthroscopy, subacromial decompression, and debridement; however, there has not been a scheduled surgery date provided. More information is needed in order to warrant the use of a cold therapy unit rental. As such, medical necessity has not been established.