

Case Number:	CM14-0123054		
Date Assigned:	08/06/2014	Date of Injury:	05/16/2009
Decision Date:	04/17/2015	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	08/04/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Connecticut, California, Virginia
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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, who sustained an industrial injury on 5/16/2009. She was diagnosed as having rotator cuff (capsule) sprain. Treatment to date has included physical therapy, medications, surgical intervention, and diagnostics including EMG (electromyography) / NCS (nerve conduction studies). Per the Primary Treating Physician's Progress Report dated 5/12/2014, the injured worker reported bilateral shoulder pain. She is status post a reverse total shoulder arthroplasty on the left. She reports pain and decreased range of motion. Physical examination revealed elevation to 90 degrees. She cannot do a belly press. She has a positive Tinels and Phalens tests at the right wrist. She also has knee pain. She has no mechanical symptoms. She has tenderness medially and the patellar tendon is swollen. The plan of care included magnetic resonance imaging (MRI). Authorization was requested for vascutherm cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vascutherm cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter - continuous flow cryotherapy.

Decision rationale: The patient underwent operative treatment of a left shoulder injury in September 2014 (left shoulder arthroplasty, removal of hardware, rotator cuff repair, glenoid reconstruction and hemi arthroplasty, and biceps tenodesis) at which time a 7 day rental of a cold therapy unit was certified. This is supported by the ODG guidelines, which state that continuous flow cold therapy is recommended as an option after surgery, but not for nonsurgical treatment. Based on the provided records and history of surgery, it is the opinion of this reviewer that the modification to a 7-day rental per utilization review as a post-operative modality was appropriate, and therefore the initial request for a cold therapy unit with an indefinite period of use is not medically necessary.