

Case Number:	CM14-0190406		
Date Assigned:	11/21/2014	Date of Injury:	08/25/2014
Decision Date:	01/16/2015	UR Denial Date:	11/05/2014
Priority:	Standard	Application Received:	11/14/2014

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:

Injured worker is a male with date of injury 8/25/2014. Per orthopedic surgeon initial evaluation dated 10/21/2014, the injured worker complains of right shoulder pain and weakness. His injury is the result of a trip and fall onto an extended right arm. Examination of the right shoulder reveals range of motion flexion 0 to 125 degrees, external rotation to 45 degrees and internal rotation to T12. Hawkins and Neer's sign are positive for impingement. There is weakness with abduction testing. Bilateral upper extremities sensation is intact to light touch, pinprick and two-point discrimination in all dermatomes in the bilateral upper extremities. Motor strength in bilateral upper extremities is 5/5 throughout. Deep tendon reflexes of bilateral upper extremities are 2+ in biceps, triceps, and brachioradialis. MRI dated 9/18/2014 revealed full thickness tear of supraspinatus tendon. Diagnosis is right shoulder impingement syndrome and rotator cuff tear.

IMR ISSUES, DECISIONS AND RATIONALES

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

Q-tech cold therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, AM J Sports Med. 1996 Mar-Apr; 24 (2):193-5

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 section

Decision rationale: The MTUS Guidelines do not address the use of continuous-flow cryotherapy. The ODG recommends 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 (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. This request does not clarify if it is for a rental or purchase, and if for rental, the length of rental. There is no rationale or explanation of this request to determine medical necessity based on the ODG. The request for Q-tech cold therapy is determined to not be medically necessary.