MAXIMUS Federal Services

Case Number:	CM15-0000672		
Date Assigned:	01/12/2015	Date of Injury:	03/18/2002
Decision Date:	03/11/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	01/02/2015

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: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 74 year old male, who sustained an industrial injury on 03/18/2002. Medical records provided did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed with impingement syndrome to the right shoulder with associated degenerative changes of the rotator cuff along with findings of a recent tear from magnetic resonance imaging performed on 12/20/2007; left shoulder rotator cuff tear per magnetic resonance imaging performed on 07/27/2004; massive full thickness rotator cuff tear with retraction of the musculotendinous unit of the supraspinatus and infraspinatus tendons and large bursal tear of the subscapularis tendon of the right shoulder per magnetic resonance imaging performed on 02/29/2012; and status post left arthroscopic rotator cuff repair, subacromial decompression, distal clavicle resection, and biceps tenodesis on 11/03/2010. Treatment to date has included Terocin patches, above noted surgery, and recent request for right shoulder surgery. Currently, the injured worker complains of right shoulder pain. The treating physician requested the use of Cold Therapy Unit to assist in post-surgical edema and pain. On 12/09/2014 Utilization Review non-certified a prescription for durable medical equipment of a cold therapy unit, noting the Official Disability Guidelines Treatment in Workers' Compensation, 19th Edition, 2014 Updates, Shoulder Procedure, Continuous-flow Cryotherapy was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME Cold Therapy Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder Chapter, Continuous-flow cryotherapy

Decision rationale: The patient presents with unrated right shoulder pain, is apparently in the preoperative phases for a right shoulder rotator cuff repair. The patient's date of injury is 03/18/02. Patient is status post left contralateral shoulder rotator cuff repair on 11/03/10, has no documented surgical history directed at right shoulder. The request is for DME COLD THERAPY UNIT. The RFA is dated 12/02/14. Physical examination dated 11/14/14 reveals positive Hawkins and Neer impingement signs to the right shoulder, pain with positive arc from 90 to 110 degrees, pain with active forward flexion, forward elevation, and abduction. The patient's current medication regimen is not provided. Diagnostic imaging pertinent to this request was not included, though progress note 11/14/14 states: "The patient has had an MRI scan confirmation of right rotator cuff tear on February 29, 2012." Patient is classified as disabled. ODG guidelines, Shoulder Chapter, under Continuous-flow cryotherapy states the following regarding postoperative cold therapy units: "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. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy are extremely rare but can be devastating."In regards to the request for a cold therapy unit, the request appears reasonable, however there is no specification of a duration of use. Cold therapy units are indicated for the management of acute pain, such as the immediate postoperative period, however it is not clear from the records provided whether the treater is requesting a purchase or a rental. In this case, a 7-day rental for the post-operative period would be appropriate, but without a clearer statement of intent to rent this unit the medical necessity cannot be substantiated. Therefore, this request IS NOT medically necessary.