

Case Number:	CM15-0134650		
Date Assigned:	07/23/2015	Date of Injury:	03/04/2014
Decision Date:	08/19/2015	UR Denial Date:	06/15/2015
Priority:	Standard	Application Received:	07/13/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 45 year old male who sustained an industrial /work injury on 3/4/14. He reported an initial complaint of right shoulder pain. The injured worker was diagnosed as having rotator cuff sprain, shoulder sprain, and rotator cuff syndrome. Treatment to date includes medication, physical therapy, activity modification, corticosteroid injection, and surgery (shoulder decompression, acromioplasty, labral debridement verses repair). MRI results were reported on 5/8/15 that demonstrated a partial rotator cuff tear. Currently, the injured worker complained of persistent right shoulder pain that was not relieved with conservative treatment. Per the operative report on 6/10/15, the injured worker had a significant tearing of the labrum anteriorly, having a Buford type complex as he had a hypertrophied superior glenohumeral ligament extending off the biceps and a very minimal amount of labral tissue anteriorly. Current plan of care included surgical procedure (arthroscopy of right shoulder with subacromial decompression and acromioplasty as well as bursal-sided rotator cuff debridement. The requested treatments include DME (durable medical equipment) of a thermal compression unit for the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME 21 day rental of a thermal compression unit for the right 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, Cold Compression Therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Shoulder (Acute & Chronic), Continuous-flow cryotherapy (2) Shoulder (Acute & Chronic), Cold compression therapy.

Decision rationale: The claimant sustained a work-related injury in March 2014 and underwent right shoulder arthroscopy on 06/10/15 with a rotator cuff debridement and rotator cuff and labral repair. Continuous-flow cryotherapy can be recommended as an option after surgery. Postoperative use generally may be up to 7 days, including home use. Cold is believed to have therapeutic benefits including decreasing inflammation and swelling. However, cold compression therapy is not recommended and the unit is being requested for three weeks. The requested cold compression device rental was not medically necessary.