

Case Number:	CM15-0136949		
Date Assigned:	07/24/2015	Date of Injury:	05/24/2014
Decision Date:	08/21/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/15/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 72-year-old female, who sustained an industrial injury on 5/24/14. She reported injury to her face, shoulders and knees after a trip and fall accident. The injured worker was diagnosed as having right shoulder full thickness tear with retraction and left shoulder rotator cuff tear status post repair. Treatment to date has included a right shoulder MRI on 5/2/15 showing a recurrent tear of the supraspinatus tendon, physical therapy and Norco. As of the PR2 dated 6/18/15, the injured worker reports 7/10 pain in her left shoulder. Objective findings include right shoulder flexion and abduction 140 degrees, internal and external rotation 60 degrees and a positive Hawkin's and Neer test. The treating physician recommended a right shoulder rotator cuff repair. The treating physician requested a polar care cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Polar care 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, 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 (Acute & Chronic), Continuous-flow cryotherapy.

Decision rationale: MTUS and ACOEM are silent regarding this topic. ODG states, "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." The patient was approved for right shoulder arthroscopy. Progress notes and request for authorization does not detail the length of time for the cold therapy unit. A 7 day post-operative time period is reasonable and within guidelines. The treating physician does not include additional information that would justify the use of a cold therapy unit in excess of the guideline recommendation. As such, the request for 1 Polar care cold therapy unit is not medically necessary.