

Case Number:	CM15-0166906		
Date Assigned:	09/04/2015	Date of Injury:	10/31/2014
Decision Date:	10/13/2015	UR Denial Date:	08/03/2015
Priority:	Standard	Application Received:	08/25/2015

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 63-year-old male who sustained an industrial injury on 10/31/14. The mechanism of injury was not documented. The 12/3/14 right shoulder MRI impression documented findings consistent with a distal rotator cuff tear, subacromial bursitis, and mild atrophy of the supraspinatus muscle. The 7/24/15 treating physician report cited persistent moderate right shoulder pain. He reported that physical therapy helped him, but overall he had not improved. He had constant pain, day and night, with inability to perform heavy pushing, pulling, and lifting activities. He was unable to perform recurrent sustained overhead activities or work tasks. Right shoulder exam documented supraspinatus atrophy and positive Neer, Hawkin's and Jobe's tests. There was acromioclavicular (AC) tenderness, and positive anterior and posterior AC joint stress tests. Shoulder range of motion was limited to flexion 150, abduction 140, and external rotation 60-70 degrees with internal rotation to T10. There was 4/5 abduction and external rotation weakness. The diagnosis was right shoulder persistent symptomatic recurrent rotator cuff tear, impingement syndrome, and distal clavicle arthrosis. The treatment plan recommended right shoulder arthroscopic rotator cuff repair and associated surgical requests. Authorization was also requested for a post-operative cold therapy unit for the right shoulder. The 7/31/15 utilization review certified the request for right shoulder arthroscopic rotator cuff repair, distal clavicle resection, and acromioplasty, post-op physical therapy 3x4, shoulder immobilizer with abduction pillow, and pre-op medical clearance. The 8/3/15 utilization review modified the request for post-op cold therapy unit to a 7-day rental of a cold therapy unit consistent with guideline recommendations.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Cold Therapy unit (for post-op shoulder rotator cuff repair):
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), 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: Continuous-flow cryotherapy.

Decision rationale: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for 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. The 8/3/15 utilization review decision recommended partial certification of a cold therapy unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.