

Case Number:	CM15-0188363		
Date Assigned:	09/30/2015	Date of Injury:	09/18/2014
Decision Date:	11/13/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/24/2015

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, North Carolina
 Certification(s)/Specialty: Family Practice

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 38 year old female, who sustained an industrial injury on 09-18-2014. The injured worker was diagnosed as having left shoulder impingement syndrome, probable left post -traumatic brachial plexopathy, and left carpal tunnel syndrome. On medical records dated 08-03-2015, the subjective complaints were noted as neck pain, left shoulder pain and left upper extremity pain. The injured worker was scheduled for a left shoulder arthroscopic decompression and left carpal tunnel release. Objective findings were noted as headaches and left arm numbness and radiation pain with neck and left should pain. A positive left brachial plexus Tinel, left carpal tunnel Tinel, and left cubital tunnel Tinel was noted. Left neck left scalene, left pectoralis minor tenderness and positive left Adson and left Roos test as well as left shoulder tenderness with mild restriction in range of motion was noted as well. Treatments to date included physical therapy and medication. Current medications were not listed on 08-03- 2015. The Utilization Review (UR) was dated 08-28-2015. A Request for Authorization was dated 08-10-2015. The UR submitted for this medical review indicated that the request for cold therapy unit-DVT compression device x 1 month rental was modified, cold therapy wrap - purchase and compression wrap - purchase for the left shoulder was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy Unit / DVT Compression Device x 1 month rental: 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 (Acute & Chronic), 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).

Decision rationale: The patient underwent left shoulder arthroscopy with subacromial decompression and a left carpal tunnel release on 8/11/15. The request is for a cold therapy unit/DVT compression device rental for 1 month. The ODG states that continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Post-operative use may be approved for up to 7 days, including home use. The request is for 1 month, which exceeds the guidelines by 3 weeks. Therefore the request is not medically necessary or appropriate.

Cold therapy wrap - purchase: 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 (Acute & Chronic), 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).

Decision rationale: In this case, since the cold therapy unit is not recommended, then the cold therapy wrap for purchase is not longer necessary. The request for the wrap accompanies a request for a continuous cold therapy unit for 1 month. Guidelines only allow for 7 days of continuous cold therapy. Therefore the request for the cold wrap is not medically necessary or appropriate.

Compression wrap - purchase for the left 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 (ODG), Shoulder (Acute & Chronic), 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).

Decision rationale: ODG states that cold compression therapy is not recommended in the shoulder due to a lack of published studies. There is no advantage to a commercial cold

compression device versus a simple ice pack held in place by an elastic wrap. The ODG does not support the use of cold compression therapy in the post-op shoulder. Therefore the request is not medically necessary or appropriate.