

Case Number:	CM15-0202167		
Date Assigned:	10/19/2015	Date of Injury:	11/06/2014
Decision Date:	12/01/2015	UR Denial Date:	10/07/2015
Priority:	Standard	Application Received:	10/14/2015

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: Utah, Arkansas

Certification(s)/Specialty: Family Practice, Sports 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 53 year old female, who sustained an industrial injury on 11-6-2014. The injured worker was being treated for supraspinatus muscle sprain and rotator cuff tear. Medical records (6-18-2015, 8-17-2015, and 9-24-2015) indicate ongoing right shoulder pain. The treating physician (8-17-2015 and 9-24-2015) noted the injured worker had re-aggravated of her shoulder in physical therapy while lifting a 40-pound box. The physical exam (6-18-2015 and 8-17-2015) reveals tenderness to palpation of the anterior shoulder, glenohumeral joint, and lateral acromion. There is decreasing of the range of motion of the right shoulder. The physical exam (9-24-2015) reveals pain and tenderness laterally at the greater tuberosity and pain with lifting above 90 degrees. On 9-11-2015, an MRI of the left shoulder revealed a supraspinatus bursal-sided and intrasubstance partial thickness tear and moderate supraspinatus tendinosis. There was a low-grade articular-sided partial thickness tear of the infraspinatus tendon. There superior labrum was small and mildly frayed. Surgeries to date include right shoulder rotator cuff surgery. Treatment has included physical therapy, acupuncture, subacromial and glenohumeral joint steroid injections, off work, work restrictions, a home exercise program, a sling, and medications including pain and non-steroidal anti-inflammatory. Per the treating physician (9-24-2015 report), the injured worker is off work. The treatment plan includes right shoulder surgery. On 9-30-2015, the requested treatments included post-operative purchase or 7-day rental of cold therapy unit for the left shoulder. On 10-7-2015, the original utilization review modified a request for 7-day rental of cold therapy unit for the left shoulder (original request for purchase or 7-day rental).

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative purchase or 7-day rental of cold therapy unit for the left shoulder:

Overtured

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

Decision rationale: MTUS does not specifically mention a cold therapy unit, but does recommend at-home applications of heat and cold and would support hot and cold packs for acute pain. ODG indicates cold therapy units for certain post-op conditions, but does not recommend equipment to apply cold therapy to the chronic pain patient. Guidelines generally recommend up to 7 days of postoperative usage of a unit. The patient is inside of the recommended time frame for usage. According to the clinical documentation provided and current MTUS guidelines; cold therapy unit, as written above, is medically necessary for the patient at this time.