

Case Number:	CM15-0202424		
Date Assigned:	10/19/2015	Date of Injury:	11/11/2013
Decision Date:	12/02/2015	UR Denial Date:	09/28/2015
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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 is a 45 year old female with a date of injury of November 11, 2013. A review of the medical records indicates that the injured worker is undergoing treatment for recurrent history of right shoulder anterior dislocation with instability, and labral tear of the right shoulder. Medical records (June 15, 2015; August 3, 2015) indicate that the injured worker complained of pain with recurrent dislocation, subluxation, and instability of the right shoulder. The physical exam (June 15, 2015; August 3, 2015) reveals positive apprehension sign, positive relocation, positive Neer test, and positive Hawkins of the right shoulder. Treatment has included magnetic resonance imaging arthrogram of the right shoulder that showed evidence of a Hill-Sachs lesion consistent with previous dislocation with fraying and tearing of the anterior and inferior labrum, and right shoulder arthroscopy with Bankart procedure and capsule labral reconstruction on September 11, 2015. The original utilization review (September 28, 2015) non-certified a request for a fourteen day rental of a cold compression unit and compression pad purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold compression unit x 14 day 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, 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) Shoulder Chapter, under Continuous-flow cryotherapy.

Decision rationale: The patient presents on 09/28/15 for a post-operative evaluation. The patient's date of injury is 11/11/13. Patient is status post right shoulder arthroscopic Bankart procedure with labral reconstruction and capsulorrhaphy on 09/11/15. The request is for COLD COMPRESSION UNIT X14 DAY RENTAL. The RFA was not provided. Physical examination dated 09/28/15 reveals well healed incisions with no evidence of infection. No other remarkable findings are included. The patient's current medication regimen is not provided. Patient is currently classified as temporarily totally disabled. Official Disability Guidelines, Shoulder Chapter, under Continuous-flow cryotherapy states the following regarding postoperative cold therapy units: 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. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy are extremely rare but can be devastating. In regard to the 14 day rental of a cold therapy unit, the provider has exceeded guideline recommendations. Per the records provided, the patient recently underwent right shoulder surgery for which the use of a cryotherapy unit is considered appropriate. However, official Disability Guidelines specify a 7 day rental for only for post-operative recovery, the request for a 14 day rental exceeds this allotment. Were the request for a 7 day rental, the recommendation would be for approval, however the current request as written exceeds guideline recommendations and cannot be substantiated. Therefore, the request IS NOT medically necessary.

Compression pad 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, 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) Shoulder Chapter, under Continuous-flow cryotherapy.

Decision rationale: The patient presents on 09/28/15 for a post-operative evaluation. The patient's date of injury is 11/11/13. Patient is status post right shoulder arthroscopic Bankart procedure with labral reconstruction and capsulorrhaphy on 09/11/15. The request is for COMPRESSION PAD PURCHASE. The RFA was not provided. Physical examination dated 09/28/15 reveals well healed incisions with no evidence of infection. No other remarkable findings are included. The patient's current medication regimen is not provided.

Patient is currently classified as temporarily totally disabled. Official Disability Guidelines, Shoulder Chapter, under Continuous-flow cryotherapy states the following: 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. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy are extremely rare but can be devastating. In regard to the compression pads associated with the cryotherapy unit, the requested unit is not approved therefore the pads are unnecessary. This patient recently underwent right shoulder surgery for which the use of cryotherapy is considered appropriate. However, the provider requested a 14 day rental of the unit and purchase of the associated pads exceeding ODG recommendations which allow only a 7 day rental post-operatively. While this patient presents with significant shoulder pain and surgical intervention, a 14 day rental exceeds guideline recommendations and therefore the associated accessories cannot be substantiated. Therefore, the request IS NOT medically necessary.