

Case Number:	CM15-0214231		
Date Assigned:	11/04/2015	Date of Injury:	12/22/2011
Decision Date:	12/15/2015	UR Denial Date:	10/21/2015
Priority:	Standard	Application Received:	10/30/2015

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, Oregon, Washington
 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:

The injured worker is a 63 year old female, who sustained an industrial injury on 12-22-2011. A review of the medical records indicates that the worker is undergoing treatment for adhesive capsulitis of the shoulder, disorder of bursa of shoulder region and lateral epicondylitis. Subjective complaints (09-14-2015) included continued right arm, shoulder and wrist pain. Objective findings (09-14-2015) included localized tenderness around the medial and lateral epicondyles of the right elbow and tenderness around the wrist circumferentially in the right upper extremity with continued residual tenderness around the right shoulder. Treatment has included Cyclobenzaprine, Meloxicam and physical therapy. On 10-01-2015, the worker reported continued significant pain. Objective findings showed active abduction beyond 90 degrees, moderate pain with forward flexion and internal rotation and significant pain with resisted motion. The physician noted that the worker had full thickness rotator cuff tear with minimal amounts of atrophy but a significant amount of pain despite conservative care. The physician noted that he worker would benefit from diagnostic arthroscopy of the right shoulder and repair of right rotator cuff to restore strength improve function and improve quality of life. Requests for surgery and purchase of a cold therapy unit were submitted. Of note, the surgical procedure was approved as per a 10-19-2015 utilization review. The rationale for the request for cold therapy unit was not documented. A utilization review dated 10-21-2015 modified a request for purchase of a cold therapy unit (post right shoulder surgery) to certification of a 7 day post-operative rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of a cold therapy unit (post right shoulder surgery): 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 / Cold compression therapy.

Decision rationale: CA MTUS/ACOEM is silent on the issue of cold compression therapy. According to the ODG, Shoulder / Cold compression therapy, it is not recommended in the shoulder as there are no published studies. It may be an option for other body parts such as the knee although randomized controlled trials have yet to demonstrate efficacy. As the guidelines do not recommend the requested DME, the shoulder cold compression therapy is not medically necessary. Thus the determination is for non-certification. Therefore, the requested treatment is not medically necessary.