MAXIMUS Federal Services

Case Number:	CM15-0043097		
Date Assigned:	03/13/2015	Date of Injury:	02/07/2014
Decision Date:	05/12/2015	UR Denial Date:	02/27/2015
Priority:	Standard	Application Received:	03/07/2015

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:

The injured worker is a 42-year-old male who sustained an industrial injury on 02/07/2014. Current diagnoses include other unspecified back disorder, brachial neuritis or radiculitis, lumbago, thoracic or lumbosacral neuritis or radiculitis, unspecified disorders of bursae and tendons in shoulder region, and arthroscopy of shoulder. Previous treatments included medication management, physical therapy, and right shoulder surgery. Current diagnostic studies included MRI of the lumbar spine and right shoulder. Report dated 02/23/2015 noted that the injured worker presented with complaints that included pain in the right shoulder, low back, neck, and left knee. Pain level was rated as 5-6 out of 10 on the visual analog scale (VAS). Physical examination was positive for abnormal findings. The treatment plan included continues medications and physical therapy, results from the MRI of the lumbar spine and right shoulder were discussed, and a prescription for a compound cream was given. Issues being requested include cold compression therapy times 14 days and compression wraps purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold compression therapy unit rental for fourteen days: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines, Shoulder Chapter, under Continuous-flow cryotherapy.

Decision rationale: The patient presents on 03/12/15 with unspecified complaints. The four previous encounters, dated 02/05/15, 02/12/15, 02/26/15, and 03/05/15 do not include any subjective complaints, either. The patient's date of injury is 02/07/14. Patient is status post unspecified left arm surgery in 2003, and unspecified shoulder surgery in 2014. The request is for cold compression therapy unit rental for fourteen days. The RFA was not provided. Physical examination dated 03/12/15 does not include any physical findings or a reason for the encounter, only a review of work/family history and a list of current medications. The patient is currently prescribed Norco, Naproxen, Prilosec, Orphenadrine, Menthoderm, Flurbiprofen/Tramadol topical cream, and Terocin patches. Diagnostic imaging included right shoulder MRI dated 12/17/14; significant findings include "Post-surgical changes with evidence of decompression of the acromioclavicular joint and prior rotator cuff repair. Supraspinatus tendinopathy, more focally. Partial thickness tear-articular side-of the mid portion of the supraspinatus tendon at its insertion extending for nearly 15mm. involves nearly 30% of its thickness. Blunted appearance of the posterior labrum, which may be torn." Patient is currently working. MTUS does not discuss Cold therapy, though ODG 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 cold compression therapy unit rental, the provider has not provided a reason for the request. Progress notes do not indicate that this patient has undergone any recent surgeries or that there are any planned surgical procedures. This patient did have an unspecified shoulder operation sometime before October 2014, as this is the earliest report to mention shoulder arthroscopy. However, there is no indication that this patient is in the immediate post-operative time frame. ODG does not support the use of such cold therapy units as a standalone treatment, only as a post-operative measure. In addition, ODG specifies a 7-day rental for post-operative use, the request for a 14-day rental also exceeds this recommendation. Without a clearer rationale as to why this unit is required, and appropriate rental duration, the medical necessity cannot be substantiated. The request is not medically necessary.

Compression 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines, Shoulder Chapter, under Continuous-flow cryotherapy.

Decision rationale: The patient presents on 03/12/15 with unspecified complaints. The four previous encounters, dated 02/05/15, 02/12/15, 02/26/15, and 03/05/15 do not include any subjective complaints, either. The patient's date of injury is 02/07/14. Patient is status post unspecified left arm surgery in 2003, and unspecified shoulder surgery in 2014. The request is for compression wrap purchase. The RFA was not provided. Physical examination dated 03/12/15 does not include any physical findings or a reason for the encounter, only a review of work/family history and a list of current medications. The patient is currently prescribed Norco, Naproxen, Prilosec, Orphenadrine, Menthoderm, Flurbiprofen/Tramadol topical cream, and Terocin patches. Diagnostic imaging included right shoulder MRI dated 12/17/14; significant findings include "Post-surgical changes with evidence of decompression of the acromioclavicular joint and prior rotator cuff repair. Supraspinatus tendinopathy, more focally. Partial thickness tear-articular side-of the mid portion of the supraspinatus tendon at its insertion extending for nearly 15mm. Involves nearly 30% of its thickness. Blunted appearance of the posterior labrum, which may be torn." Patient is currently working. MTUS does not discuss Cold therapy, though ODG 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 purchase of a compression wrap, the provider has not provided a reason for the request. Progress notes do not indicate that this patient has undergone any recent surgeries or that there are any planned surgical procedures. This patient did have an unspecified shoulder operation sometime before October 2014, as this is the earliest report to mention shoulder arthroscopy. However, there is no indication that this patient is in the immediate post-operative time frame. It is not clear if the request is for a standard compression wrap or for a component of the associated cold compression therapy unit. There is no documentation of edema or other lymphatic insufficiency, which would necessitate a standard compression wrap. Without a clear rationale as to why compression therapy is required for this patient, or documentation of an upcoming procedure, the medical necessity cannot be substantiated. The request is not medically necessary.