

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0044990 | | |
| Date Assigned: | 03/16/2015 | Date of Injury: | 10/09/2012 |
| Decision Date: | 05/01/2015 | UR Denial Date: | 02/12/2015 |
| Priority: | Standard | Application Received: | 03/09/2015 |

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 46 year old male who sustained an industrial injury on 10/09/2012. The mechanism of injury or initial complaints is not in the submitted records. He presents on 01/15/2015 with complaints of pain in right shoulder with increased stiffness and decreased range of motion. Physical exam reveals limited and painful range of motion. Treatment to date includes physical therapy and repair of right rotator cuff tear. Diagnoses includes right rotator cuff tear (repair 08/13/2014), right frozen shoulder and cervical HNP with radiculopathy. The request is for cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder (updated 10/31/14) 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 Neck & Upper Back Chapter, Continuous-flow cryotherapy.

Decision rationale: The most recent PTP Progress report is dated 01/15/15 and states that the patient presents with pain, discomfort and stiffness with no improvement in range of motion for the right shoulder. There is also increasing pain in the right scapula and upper back. He is s/p right shoulder arthroscopy 08/13/14. The patient's listed diagnoses are: Right rotator cuff tear, Right Frozen shoulder, and Cervical HNP. The current request is for cold therapy unit. The RFA is not included; however, the 02/12/15 utilization review references RFA's dated 11/19/14 and 12/02/15. ODG, Shoulder Chapter, Continuous-flow cryotherapy, states, "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." ODG, Neck & Upper Back Chapter, Continuous-flow cryotherapy, states, "Not recommended in the neck." The reports provided for review do not discuss the reason for this request. The 01/15/15 Progress report states merely, "cold therapy unit." This patient has both neck and shoulder complaints. ODG does not recommend use for the neck. Use for the shoulder is recommended up to 7 days post-operatively. In this case, it does not appear that this request is for post-operative treatment as the treating physician's discussion of this unit and the referenced RFA's are at least 3 months past the documented right shoulder arthroscopy. Furthermore, post-surgical use is recommended up to 7 days and this request as presented above is for an indeterminate period and body part. The request IS NOT medically necessary.