

Case Number:	CM15-0046731		
Date Assigned:	03/18/2015	Date of Injury:	10/26/2012
Decision Date:	04/24/2015	UR Denial Date:	02/27/2015
Priority:	Standard	Application Received:	03/11/2015

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 32-year-old female, who sustained an industrial injury on October 26, 2012. The injured worker reported neck, shoulder, back, right arm, elbow and wrist/hand pain and difficulty sleeping. The injured worker was diagnosed as having carpal tunnel syndrome, volar forearm cyst, rotator cuff subscapularis and supraspinatus convex configuration suggesting subdeltoid bursitis, epicondylitis and neck and low back pain. A supplemental report dated February 23, 2015 is the only record provided and notes the injured worker complains of minimal neck and low back pain and shoulder pain. Objective findings provide a positive Phalen's test. There is reference to an evaluation dated January 9, 2015 with some disagreement on the findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

URGENT Coolcare Therapy unit: 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines shoulder chapter, continuous flow cryotherapy.

Decision rationale: This patient has a date of injury of 10/26/2012 and continues to complain of right shoulder pain. The medical file provided for review does not include a request for authorization form. The current request is for urgent Coolcare therapy unit. MTUS and ACOEM Guidelines do not specifically discuss Coolcare therapy units. Therefore, ODG Guidelines are referenced. ODG Guidelines under the shoulder chapter has the following regarding continuous flow cryotherapy: "Recommended as an option after surgery but not for non-surgical treatment. Postoperative use generally may be up to 7 days including home use. In the postoperative setting, continuous-flow therapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated." Ultrasound of the right shoulder dated 09/23/2013 documented a near full-thickness tear of the supraspinatus tendon and partial tear of the articular surface of the subscapular tendon. The treating physician has recommended a right shoulder arthroscopy. According to progress report dated 02/23/2015, "authorization has not been forthcoming." It appears that the cold therapy unit is being requested for postoperative treatment. However, there is no indication that the surgery has been approved. Furthermore, MTUS Guideline recommends the duration of postoperative use to be 7 days. This request is for the unit without specifying duration of use. This request is not medically necessary.

URGENT Home continuous passive motion (CPM) device for initial period of 45 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), Shoulder.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines shoulder chapter, passive motion devices (CPM).

Decision rationale: The current request is for urgent home continuous passive motion (CPM) device for initial period of 45 days. The ACOEM and MTUS Guidelines do not discuss continuous passive motion devices. Therefore, ODG Guidelines were consulted. ODG under its shoulder chapter has the following regarding passive motion devices (CPM), "Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week." ODG further states, "Rotator cuff tear: Not recommended after shoulder surgery or for non-surgical treatment." In this case, the medical reports do not document adhesive capsulitis, for which CPM devices are indicated for. The patient does not meet the criteria provided by ODG for a CPM device and there is no discussion for this device. This request is not medically necessary.