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| Case Number: | CM15-0235503 | | |
| Date Assigned: | 12/11/2015 | Date of Injury: | 12/20/2004 |
| Decision Date: | 01/19/2016 | UR Denial Date: | 11/02/2015 |
| Priority: | Standard | Application Received: | 12/02/2015 |

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 67 year old female who sustained an industrial injury on 12-20-04. A review of the medical records reveals the injured worker is undergoing treatment for strain of muscles and tendons of the right shoulder rotator cuff, incomplete rotator cuff tear or rupture, and bicipital tendinitis right shoulder. Medical records (10-12-15) reveal the injured worker complains of ongoing right shoulder pain and difficulty lifting. Her pain is not rated. The physical exam (10-12-15) reveals impingement of the right shoulder, as well as weakness with external rotation and abduction. Range of motion is restricted. Prior treatment includes Percocet and Norco. The treating provider reports the pan of care includes right shoulder surgery. The original utilization review (11-02-15) non-certified the request for 30 day rental of an intermittent cold therapy limb compression device.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 day rental of intermittent cold therapy limb compression device (DOS 10/28/15): 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, 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) (1) Shoulder (Acute & Chronic), Continuous-flow cryotherapy (2) Shoulder (Acute & Chronic), Cold compression therapy.

Decision rationale: The claimant has a remote history of a work injury in December 2004 and is being treated for right shoulder pain. She has a history of poorly controlled diabetes including a hemoglobin A1C of 12/5 mg/dL on 07/23/15 and 12.6 mg/dL on 10/18/15. When seen, she was having ongoing right shoulder pain and difficulty lifting. Physical examination findings included right shoulder impingement with decreased range of motion and weakness. A right subacromial decompression with rotator cuff repair was requested with post-operative care to include a 30 day rental of a cold therapy compression unit. Continuous-flow cryotherapy can be recommended as an option after surgery. Postoperative use generally may be up to 7 days, including home use. Cold is believed to have therapeutic benefits including decreasing inflammation and swelling. However, cold compression therapy is not recommended. The requested cold compression device rental for 30 days is not medically necessary.