

Case Number:	CM15-0238443		
Date Assigned:	12/15/2015	Date of Injury:	07/02/2014
Decision Date:	01/21/2016	UR Denial Date:	12/02/2015
Priority:	Standard	Application Received:	12/07/2015

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: Illinois, California, Texas
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:

This injured worker is a 63-year-old male who sustained an industrial injury on 7/2/14. Injury occurred relative to cumulative trauma, including repetitive lifting and overhead use. The 6/23/15 left shoulder MRI impression documented a full thickness tear of the supraspinatus tendon, retracted 9 mm and measuring 9 mm anterior to posterior. There was some mild tendinosis of the supraspinatus and infraspinatus tendons. There was severe arthrosis of the acromioclavicular (AC) joint with a type 3 acromion. There was tendinosis of the intra-articular portion of the long head biceps tendon. There was a SLAP tear. The 11/16/15 treating physician report cited continued left shoulder pain, aggravated by overhead reaching and sleeping. Left shoulder exam documented tenderness at the AC joint, limited range of motion, pain and weakness with abduction strength testing, pain but no weakness with external rotation strength testing, and positive impingement sign. O'Brien's test was positive. Anterior and posterior apprehension signs were negative. Left shoulder x-rays showed a type 3 acromion with an eyebrow sign and degenerative AC joint changes. Authorization was requested for left shoulder acromioplasty, possible biceps tenodesis, and possible rotator cuff repair, with associated surgical services including a cold therapy unit purchase. The 12/2/15 utilization review certified the request for left shoulder acromioplasty, possible biceps tenodesis, and possible rotator cuff repair. The associated request for a cold therapy unit purchase was modified to a 7-day rental of a cold therapy unit consistent with the Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Service: Cold Therapy Unit purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG 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: Continuous-flow cryotherapy.

Decision rationale: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for 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. The 12/2/15 utilization review recommended partial certification of a cold therapy unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.