

Case Number:	CM14-0145772		
Date Assigned:	09/12/2014	Date of Injury:	07/04/2013
Decision Date:	10/14/2014	UR Denial Date:	09/02/2014
Priority:	Standard	Application Received:	09/08/2014

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. The expert reviewer is Board Certified in Orthopaedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 61-year-old male sustained an industrial injury on 7/4/13. The mechanism of injury was not documented. The 12/17/13 right shoulder MRI impression documented an intrasubstance minor split tear of the supraspinatus tendon, partial thickness tearing of the distal subscapularis tendon, and degeneration and possible old degenerative tearing of the posterior-superior labrum. There was a hook-like distal acromion with lateral downsloping. The 8/14/14 treating physician report indicated that the patient had three weeks of pain relief with a cortisone injection but pain had returned in the anterolateral deltoid region. Physical exam documented right shoulder range of motion 170/90/80. There was acromioclavicular joint tenderness and positive impingement sign. The treatment plan recommended right shoulder acromioplasty, Mumford, possible labral repair, possible biceps tenodesis, and possible rotator cuff repair. Associated requests included pre-operative labs, EKG, post-op physical therapy, purchase of a cold therapy unit, and a shoulder immobilizer. The 9/2/14 utilization review approved the requested surgery, pre-operative labs, EKG, post-op physical therapy, and shoulder immobilizer. The request for purchase of a cold therapy unit was modified and approved for a 7 day rental consistent with guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 surgery. 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. The 9/2/14 utilization review decision recommended partial certification of this cold therapy device for 7-day use. There is no compelling reason in the records reviewed to support the medical necessity of a cold device beyond the 7-day rental recommended by guidelines and previously certified. Therefore, the request for Cold Therapy Unit is not medically necessary.