

Case Number:	CM14-0213068		
Date Assigned:	12/30/2014	Date of Injury:	09/05/2013
Decision Date:	02/27/2015	UR Denial Date:	12/15/2014
Priority:	Standard	Application Received:	12/19/2014

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. 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 & Rehabn

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 patient is a 69 year old male with an injury date on 9/5/13. The patient complains of numbness in the medial forearm and fingertips per 11/19/14 report. The patient's moderate pain is controlled by Norco and ice per 11/19/14 report. The 9/11/14 report (pre-operative) states the patient has left shoulder pain that is worse with use or overhead movement, rated 7-8/10 with medications and 2-3/10 with medication. Based on the 11/19/14 progress report provided by the treating physician, the diagnosis is s/p left subscapularis repair, biceps tenodesis, acromioplasty, and Mumford. A physical exam on 11/19/14 showed "left shoulder wounds are dry with minimal bruising. Passive range of motion is 90/0." The patient's treatment history includes medications, cryotherapy. The treating physician is requesting retro review for a water circulating cold pad with pump for DOS 11/14/14. The utilization review determination being challenged is dated 12/15/14. The requesting physician provided treatment reports from 5/12/14 to 11/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro review for a water circulating cold pad with pump for DOS 11/14/14: 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)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder chapter, continuous-flow cryotherapy.

Decision rationale: This patient presents with left shoulder pain, numbness in medial forearm/fingertips and is s/p left subscapularis repair, biceps tenodesis, acromioplasty, and Mumford from 11/14/14. The treater has asked for retro review for a water circulating cold pad with pump for DOS 11/14/14 but the requesting progress report is not included in the provided documentation. Regarding continuous-flow cryotherapy, ODG shoulder chapter recommends as an option after surgery, but not for nonsurgical treatment. ODG states: "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; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs." In this case, the patient is s/p left shoulder surgery. The treater has requested continuous flow cryotherapy unit on 11/14/14, which was the date of surgery. It appears the request is for a cryotherapy unit for use during surgery, which is not indicated by ODG guidelines. ODG only recommends postoperative use for 7 days. In addition, the request does not state it is for a 7-day rental as per ODG guidelines. The request IS NOT medically necessary.