

Case Number:	CM14-0214639		
Date Assigned:	01/02/2015	Date of Injury:	08/07/2012
Decision Date:	02/28/2015	UR Denial Date:	12/04/2014
Priority:	Standard	Application Received:	12/23/2014

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 & 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 patient is a 55 year old female with an injury date of 08/07/12. Based on the 11/07/14 progress report, the patient complains of left shoulder pain. The patient underwent arthroscopic release of the left shoulder on 10/07/14. The left shoulder elevates to about 130, abducts to 70, externally rotates to neutral and internally rotates to the buttocks. The treatment plan includes continuing with physical therapy and take Flexeril for pain. The patient is temporarily totally disabled. Based on the 11/03/14 progress report, the pain of left shoulder radiates to the arm. The pain is moderate, constant, aching, and stabbing with stiffness. The pain is relieved with ice and increases with internal rotation, abduction, and nighttime. The patient also complains of back pain, headaches, and fatigue. The current medications are Janumet, Altace, Zocor, Dilaudid, Percocet, Trazodone HCL, Aleve, Aspirin, and Glucotrol. The left shoulder exam shows pain elicited anteriorly and posteriorly. The diagnoses are: 1. Shoulder pain. 2. Patient visit for long term (current) drug use, other. 3. Degeneration of lumbar disc. The treating physician is requesting for Vascutherm Cold Therapy unit 7 day rental on 11/18/14. The utilization review determination being challenged is dated 12/04/14. The requesting physician provided treatment reports from 06/18/14-11/07/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vascutherm cold therapy unit x 7: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. 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 shoulder chapter, continuous flow cryotherapy

Decision rationale: The patient presents with left shoulder pain. The request is for VASCUTHERM COLD THERAPY UNIT 7 DAYS RENTAL. The patient underwent arthroscopic release of the left shoulder dated 10/07/14. According to utilization review letter dated 12/04/14, the patient was approved for 7 day rental of cryotherapy unit. MTUS is silent on hot/cold therapy units. ODG guidelines shoulder chapter discuss continuous flow cryotherapy and states recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In this case, the request was already authorized for post-op use per UR letter. It does not appear the request is for additional 7 days of rental. ODG allows for 7 days post-op use of cold therapy units, and the request IS medically necessary.