

Case Number:	CM15-0120830		
Date Assigned:	07/01/2015	Date of Injury:	01/13/2015
Decision Date:	07/30/2015	UR Denial Date:	06/15/2015
Priority:	Standard	Application Received:	06/22/2015

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: 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 injured worker is a 61-year-old male, who sustained an industrial injury on 1/13/15. He reported a sharp pain in the right shoulder followed by weakness and the inability to raise his arm above his head. The injured worker was diagnosed as having a full thickness tear of the rotator cuff. Treatment to date has included MRI, acupuncture, cardiology/respiratory testing and medication. Currently, the injured worker complains of severe neck pain, stiffness and cramping rated at 6/10. He also complains of upper/mid pain, stiffness and cramping, which is constant and rated moderate. He has occasional moderate low back pain accompanied by stiffness and cramping rated at 7/10. He has left shoulder pain, stiffness and cramping rated as occasional and moderate. His right shoulder is painful accompanied by stiffness and cramping, it is constant and severe rated 7-8/10. He also reports sleep disturbance. The diagnosis of rotator cuff rupture and shoulder arthralgia has resulted in the work status of, off work. A note dated 2/17/15 states there is a decreased range of motion, weakness and signs of impingement of the right shoulder. Neurologic examination of his upper extremities revealed no deficits. On 4/13/15, an acupuncturist evaluated the injured worker, therapeutic efficacy was not included. The note states there is visible decrease in range of motion in the neck, bilateral shoulder and low back with moderate spasm of the bilateral upper trapezius, cervical, thoracic and lumbar paravertebral musculature. A 5/15/15 note states there is tenderness noted in the cervical, thoracic and lumbar spine accompanied by spasms. Tenderness to palpation, a decreased range of motion and pain with range of motion is noted in his shoulders bilaterally. The injured worker is a candidate

for surgical intervention; therefore, a post-operative cold therapy unit (purchase vs. rental) is being requested to aid him in his post-operative recovery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post op cold therapy unit (purchase vs rental): 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 (updated 05/04/15) 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 Chapter, pages 909-910.

Decision rationale: Review indicates the patient's shoulder arthroscopy has been certified along with post-op PT and pre-op diagnostics. The current unspecified cold therapy unit was modified for a 7-day post-op rental. Rehabilitation to include mobility and exercise are recommended post-surgical procedures as a functional restoration approach recommended by the guidelines. MTUS Guidelines is silent on specific use of cold/heat compression therapy, but does recommend standard cold pack for post exercise. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post-surgery; however, limits the use for 7-day post-operative period, as efficacy has not been proven after. Submitted reports have not demonstrated extenuating circumstances beyond guidelines criteria. The Post op cold therapy unit (purchase vs. rental) is not medically necessary and appropriate.