

Case Number:	CM15-0063365		
Date Assigned:	04/20/2015	Date of Injury:	05/28/2010
Decision Date:	05/18/2015	UR Denial Date:	03/10/2015
Priority:	Standard	Application Received:	04/03/2015

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, Pain Management

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 59 year old male, who sustained an industrial injuries from 03/21/2000 through 05/26/2010 with a reported date of injury 05/28/2010. The initial complaints or symptoms included injuries to the low back, left hip, left ankle, left knee, right shoulder and left shoulder. The initial diagnoses were not mentioned in the clinical notes. Treatment to date has included conservative care, medications, multiple surgical procedures to multiple body parts (left elbow - 2000, right shoulder - 2001, 2003 and 2005, left shoulder - 2004), x-rays and MRIs, conservative therapies, and electrodiagnostic testing. Currently, the injured worker complains of aching discomfort in the right shoulder with limited range of motion and limited active movements in the right upper extremity. The diagnoses include history of industrial injury with subsequent arthroscopic debridement as indicated and rotator cuff repair of the right shoulder with recurrent full-thickness rotator cuff tear (per MRI 02/16/2015), history of left shoulder arthroscopic surgery, persistent low back pain and left hip pain. The treatment plan consisted of arthroscopic surgical procedure to the right shoulder, pre-operative medical clearance and testing, cold therapy unit with pads for the right shoulder (denied), post-op durable medical equipment, and follow-up.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy Unit with Pads for the Right Shoulder: 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), Treatment Index, 13th Edition (web) 2015, Shoulder, Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation X Official Disability Guidelines (ODG), Shoulder Chapter, Continuous-flow cryotherapy section.

Decision rationale: Regarding the request for Cold Therapy Unit. ODG cites that continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use, but not for non-surgical treatment. Within the documentation available for review, while up to 7 days of use would be appropriate after surgery, there is no support for an open-ended rental or purchase and, unfortunately, there is no provision for modification of the current request. As such, the currently requested Cold Therapy Unit is not medically necessary.