

Case Number:	CM14-0064899		
Date Assigned:	07/11/2014	Date of Injury:	09/24/2012
Decision Date:	11/19/2015	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/07/2014

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: Preventive Medicine, Occupational Medicine

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 39 year old male, who sustained an industrial injury on 9-24-2012. Several documents within the submitted medical records are difficult to decipher. The injured worker is undergoing treatment for rotator cuff tear with repair on 3-21-2014. Medical records dated 3-4-2014 indicate the injured worker complains of unchanged left shoulder pain. Physical exam dated notes left shoulder tenderness to palpation with decreased range of motion (ROM) and positive impingement. An operative report dated 3-21-2014 indicates the injured worker underwent successful arthroscopic left shoulder rotator cuff repair. There is a request for treatment for post-operative durable medical equipment (DME) dated 3-21-2014. Treatment to date has included ice, home exercise program (HEP), pre-operative clearances, medication and physical therapy. The original utilization review dated 5-4-2014 indicates the request for cold therapy unit related to left shoulder for date of service 3/21/14 , cold pad related to left shoulder for date of service 3/21/14 and shoulder wrap related to left shoulder for date of service 3/21/14 is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit related to left shoulder for date of service 3/21/14: Overturned

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability guidelines.

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 Cooling and Other Medical Treatment Guidelines <http://www.dme-direct.com/donjoy-iceman-cold-therapy-unit>.

Decision rationale: MTUS Guidelines do not address this post operative request. ODG Guidelines address this issue in some detail and support up to 7 days of use post operative. The particular unit requested is an "iceman" unit which due to its low cost does (Approx \$150.00) not appear to be utilized as a rental unit. This unit is also not designed to include compression, which would not be supported by Guidelines. Under these circumstances, the request for the Cold therapy unit related to left shoulder for date of service 3/21/14 is consistent with Guidelines and is medically necessary.

Cold pad related to left shoulder for date of service 3/21/14: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability guideline.

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 Cooling and Other Medical Treatment Guidelines <http://www.dme-direct.com/donjoy-iceman-accessories-parts-pads-power>.

Decision rationale: This request is directly related to the request for the post operative cooling unit. However, the medical necessity for a cooling pad in addition to the shoulder pad is not apparent. A review of the accessories available fails to provide support for a pad in addition to the shoulder specific pad that would be utilized post shoulder surgery. There are no unusual circumstances supporting an exception to the medical necessity for this pad. The Cold pad related to left shoulder for date of service 3/21/14 is not medically necessary.

Shoulder wrap related to left shoulder for date of service 3/21/14: Overturned

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability guideline.

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 Cooling and Other Medical Treatment Guidelines <http://www.dme-direct.com/donjoy-iceman-accessories-parts-pads-power>.

Decision rationale: This request for a shoulder wrap is directly related to the request for the post-operative cooling unit. The shoulder wrap is specific for this individual's condition and is reasonable and necessary for the use of this cooling unit post shoulder surgery. The Shoulder wrap related to left shoulder for date of service 3/21/14 is/was medically necessary.