

Case Number:	CM13-0023529		
Date Assigned:	12/13/2013	Date of Injury:	04/03/2001
Decision Date:	11/06/2014	UR Denial Date:	09/09/2013
Priority:	Standard	Application Received:	09/12/2013

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 62 year old male with a reported date of injury on 10/15/2013. The mechanism occurred when the injured worker fell over and hurt his shoulder. The clinical report given stated the injured worker had right shoulder pain and could not sleep. The injured worker stated he had night pain and pain at rest. The injured worker stated he had pain with overhead movements and reaching behind as well as pain anteriorly and laterally. The injured workers medication regimen was not provided for review. The clinical note dated 08/26/2013 noted the injured worker was status post attempted arthroscopic cuff repair dated 01/2005, which failed and status post open cuff repair dated 08/2005. According to the medical record dated 08/26/2013, the injured worker tried ibuprofen. The injured worker underwent physical therapy, cortisone and surgery without significant benefit. The request for authorization was submitted 10/15/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 561-563.

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 - Flow Cryotherapy.

Decision rationale: The clinical noted stated the injured worker had right shoulder pain and could not sleep. The injured worker stated he had night pain and rest pain. The injured worker stated he had pain with overhead movements and reaching behind as well as pain anteriorly and laterally. The clinical note dated 08/26/2013 noted the injured worker was status post attempted arthroscopic cuff repair dated 01/2005, which failed and status post open cuff repair dated 08/2005. The injured worker underwent physical therapy, cortisone and surgery without significant benefit. The Official Disability Guidelines recommended cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. It was unclear injured worker underwent surgical intervention or was scheduled to undergo surgical intervention in the near future. The requesting physician's rationale for the request was unclear. The request did not specify the number of days the unit was being requested for. Additionally, the the requesting physician did not submit any recent clinical documentation including an assessment of the injured workers condition in order to establish the medical necessity for a cryotherapy unit. Therefore, the request is not medically necessary.