

Case Number:	CM13-0026873		
Date Assigned:	03/19/2014	Date of Injury:	02/07/2012
Decision Date:	11/25/2014	UR Denial Date:	09/18/2013
Priority:	Standard	Application Received:	09/20/2013

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 Occupational Medicine and is licensed to practice in California. 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:

Patient is a 64 year-old female with date of injury 02/07/2012. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 09/09/2013, lists subjective complaints as left sided neck pain with radicular symptoms to the left shoulder arm, and all digits. Objective findings: Examination of the cervical spine revealed tenderness to the paravertebral musculature and trapezius. Range of motion was restricted. Left shoulder examination revealed supraspinatus tenderness and positive impingement test. Range of motion was restricted and motor strength was 4+/5. Patient has failed non-operative treatment to the left shoulder consisting of physical therapy and injections. Physician purports that patient is a candidate for left shoulder arthroscopic surgery. Diagnosis: 1. Local primary osteoarthritis of the left shoulder 2. Shoulder acromioclavicular arthritis 3. Joint pain, shoulder 4. Cervical disc degeneration 5. Cervicalgia 6. Brachial neuritis 7. Shoulder impingement/bursitis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit, purchase or rental for 14 days: 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), Knee Chapter

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

Decision rationale: The Official Disability Guidelines recommend continuous-flow cryotherapy as an option after surgery, but not for non-surgical treatment. Post-operative use generally may be up to 7 days, including home use. The request exceeds that which is recommended in the Guidelines. Cold Therapy Unit purchase or rental for fourteen (14) days is not medically necessary.