

Case Number:	CM13-0050408		
Date Assigned:	12/27/2013	Date of Injury:	11/14/2003
Decision Date:	07/07/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/29/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Orthopedic Surgery, 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 Physician 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 60-year-old female who reported an injury on 11/14/2003. The mechanism of injury was not specifically stated. Current diagnoses include status post left knee arthroscopy on 11/15/2012, tendinosis in the bilateral wrists and hands, bilateral shoulder rotator cuff tear, cephalgia, memory loss, diabetes mellitus, bilateral carpal tunnel syndrome, right knee meniscus signal changes, cervical spine sprain with degenerative disc disease, and lumbar spine sprain with degenerative disc disease. The injured worker was evaluated on 09/16/2013. The injured worker reported persistent lower back pain, bilateral shoulder pain, left wrist/hand pain, and right knee pain. Physical examination revealed muscle guarding and spasm in the cervical spine with painful range of motion and tenderness to palpation, tenderness of the bilateral acromioclavicular joints, positive impingement sign bilaterally, painful range of motion of the bilateral shoulders, 4/5 rotator cuff strength bilaterally, guarding and muscle spasm in the lumbar spine, painful range of motion of the bilateral knees, and decreased sensation to light touch in the bilateral wrists and hands. Treatment recommendations at that time included authorization for a right shoulder arthroscopy with an interferential unit, and a cold unit for postoperative care.

IMR ISSUES, DECISIONS AND RATIONALES

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

RENTAL OF HOT/COLD COMPRESSION UNIT FOR 60 DAYS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Continuous Flow Cryotherapy.

Decision rationale: The Official Disability Guidelines indicate that continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. According to the documentation submitted, the injured worker is awaiting authorization for a right shoulder arthroscopy. The total duration of treatment was not specified in the current request. Therefore, the request is not medically appropriate. As such, the request is not medically necessary.