

Case Number:	CM13-0054599		
Date Assigned:	12/30/2013	Date of Injury:	09/23/2011
Decision Date:	04/28/2014	UR Denial Date:	11/01/2013
Priority:	Standard	Application Received:	11/19/2013

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 and Rehabilitation 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:

This is a female patient with the date of injury of September 23, 2011. A utilization review determination dated November 1, 2013 recommends non-certification of 2 of 6 outpatient right shoulder arthroscopic subacromial decompression and 6 of 6 durable medical equipment, cold therapy unit rental x 14 days. The previous reviewing physician recommended non-certification of 6 of 6 durable medical equipment, cold therapy unit rental x 14 days due to surgical intervention deemed not necessary. A Request for Authorization for Shoulder Arthroscopic Surgery dated October 15, 2013 identifies Subjective Complaints of right shoulder pain and weakness, which is worse with overhead activity. The patient's symptoms have not responded to conservative treatment including physical therapy, chiropractic care, acupuncture, anti-inflammatory medications and a cortisone injection. Objective Findings identify decreased range of motion as well as positive impingement signs. Diagnoses identify right shoulder impingement syndrome. Treatment Plan and Recommendations identify right shoulder arthroscopic subacromial decompression.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 OF 6 DURABLE MEDICAL EQUIPMENT, COLD THERAPY UNIT RENTAL X14:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, SHOULDER (ACUTE & CHRONIC)

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 SECTION.

Decision rationale: Regarding the request for 6 of 6 durable medical equipment, cold therapy unit rental x 14 days, California MTUS does not address the issue. ODG cites that continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use. However, surgery has been non-certified. In addition, there is no evidence-based support for the use of cold therapy for 14 days. In light of the above issues, the currently requested 6 of 6 durable medical equipment, cold therapy unit rental x 14 days is not medically necessary.