

Case Number:	CM13-0060881		
Date Assigned:	05/21/2014	Date of Injury:	04/08/2013
Decision Date:	07/11/2014	UR Denial Date:	11/20/2013
Priority:	Standard	Application Received:	12/02/2013

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 Orthopaedic Surgery 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 50 year-old female sustained an industrial injury on 4/8/13. The mechanism of injury is not documented. The 6/4/13 right shoulder MRI documented moderate acromioclavicular joint arthrosis with inferior projecting osteophytes, type I lateral downsloping acromion narrowing the lateral supraspinatus outlet, mild supraspinatus tendinosis, mild bicipital tenosynovitis, and degeneration of the posterior labrum, no tear. The 11/8/13 treating physician report cited continued right shoulder discomfort that had failed conservative treatment including physical therapy and medications. Physical exam findings documented subacromial tenderness and positive Neer and Hawkin's impingement signs. The diagnosis was right shoulder bursitis, degenerative labral tearing, and biceps tenosynovitis. The treatment plan recommended right shoulder arthroscopy, subacromial decompression, debridement, and probable biceps tenodesis. A request for post-operative durable medical equipment included a cold therapy unit. The 11/20/13 utilization review denied the request for cold therapy unit because the surgery was not certified. The progress reports subsequent to this request continue to note that the surgery was denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

POST-OPERATIVE DME: COLD THERAPY UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints 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: Under consideration is a request for post-operative durable medical equipment: cold therapy unit. The California MTUS are silent regarding cold therapy units. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Given that the right shoulder arthroscopic surgery has been denied, this request for Post-Operative Durable Medical Equipment, Cold Therapy Unit, is not medically necessary.