

Case Number:	CM13-0066597		
Date Assigned:	01/03/2014	Date of Injury:	05/24/2012
Decision Date:	06/02/2014	UR Denial Date:	11/18/2013
Priority:	Standard	Application Received:	12/16/2013

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 Pain 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:

The patient is a 36 year-old male who was injured on 05/24/2012 when he was pressurizing several totes (metal containers) when one of the totes exploded due to a defective release valve. Treatment to date has included chiropractic treatment, the use of a TENS unit, ESWT, acupuncture, physical therapy and medications. MRI of the left shoulder performed 06/19/2013 reported mild degenerative changes of the AC joint with small quantity of fluid within the subacromial bursa. No labral or tendon tears. Ortho follow up dated 12/23/2013 documents the patient with continued complaints of left shoulder pain and weakness that have not responded to conservative treatments. On examination, there is decreased ROM, weakness and a positive impingement sign. The diagnosis was left shoulder AC joint osteoarthritis and left shoulder arthroscopy was recommended with post operative care.

IMR ISSUES, DECISIONS AND RATIONALES

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

COLD THERAPY UNIT FOR THE LEFT SHOULDER, 14 DAY RENTAL: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder Chapter, Continuous Flow Cryotherapy.

Decision rationale: According to the ODG, a cold therapy unit is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. Post operatively the units have proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated as an option after surgery, but not for nonsurgical treatment. The medical records document the patient's physician has requested authorization for left shoulder surgery, however, this has not yet been approved. The request is not medically necessary at this time. In addition, the request is for a 14 day rental and the guidelines recommend a total of 7 days for the rental.