

Case Number:	CM14-0105217		
Date Assigned:	07/30/2014	Date of Injury:	06/26/2012
Decision Date:	11/25/2014	UR Denial Date:	06/09/2014
Priority:	Standard	Application Received:	07/08/2014

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 Orthopedic Surgery and is licensed to practice in Minnesota. 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 injured worker is a 35 year old female with bilateral neck and upper extremity pain related to an injury date of 6/1/2012. Documentation indicates left shoulder tendinitis with impingement, sprain/strain, left wrist with recurrent ganglion cyst, triggering, left thumb and index finger, left elbow pain and bilateral wrist pain. She has been placed on medications but no corticosteroid injections or physical therapy is documented. Diagnostic testing for impingement syndrome using a Lidocaine injection into the subacromial space is not documented. The disputed issues include a request for open left shoulder subacromial decompression, post-operative cryotherapy and postoperative physical therapy. The medical records were reviewed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative Cold Therapy Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section Shoulder, Topic: Continuous flow cryotherapy

Decision rationale: The California MTUS does not address this issue. According to Official Disability Guidelines continuous flow cryotherapy is recommended as an option after shoulder surgery for 7 days. It reduces the pain, inflammation, swelling and need for narcotic usage. The request as stated does not specify the duration of the rental or whether a purchase is requested. Without knowing the length of the rental the medical necessity of the requested cryotherapy cannot be established. Therefore, this request is not medically necessary.