

Case Number:	CM14-0019231		
Date Assigned:	04/21/2014	Date of Injury:	02/08/2013
Decision Date:	07/02/2014	UR Denial Date:	01/27/2014
Priority:	Standard	Application Received:	02/14/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 patient is a 27-year-old female with date of injury 02/08/2013. Per treating physician's report 01/20/2014, the patient has a diagnosis of right shoulder impingement, subacromial bursitis. The patient presented with right shoulder pain with any range of motion, right shoulder injection helps temporarily and examination showed positive impingement signs and reduced range of motion. Request was for arthroscopic surgery of the right shoulder, Mumford surgery, and physical therapy 3 times a week for right shoulder. The request for postoperative cold therapy unit was denied by utilization review 01/27/2014 with a rationale that there was no ODG Guidelines support for this.

IMR ISSUES, DECISIONS AND RATIONALES

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

POST-OP COLD THERAPY UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: This patient presents with chronic right shoulder pain which right shoulder surgery has been recommended. The request is for postoperative continuous-flow cold therapy unit. Official Disability Guidelines (ODG) Guidelines does recommend cryotherapy for shoulder as an option after surgery but not for nonsurgical treatment for. Postoperative use generally may be up to 7 days, however. The current request does not specify the number of days requested for the use of cold therapy unit. Without specific prescription as to how long it is going to be used, the request cannot be authorized given the specific recommendation of up to 7 days for cryotherapy following shoulder surgery per (ODG) Guidelines. I was not able to find the request for authorization or the specific report containing the request to verify the duration of the request. The requested treatment is not medically necessary and appropriate.