

Case Number:	CM14-0152490		
Date Assigned:	09/22/2014	Date of Injury:	02/17/2010
Decision Date:	10/21/2014	UR Denial Date:	08/27/2014
Priority:	Standard	Application Received:	09/18/2014

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 & 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:

Patient is a 42-year-old male who has submitted a claim for left shoulder adhesive capsulitis, left shoulder impingement syndrome, left shoulder acromioclavicular joint osteoarthritis, and status post left shoulder arthroscopy, subacromial decompression and distal clavicle excision associated with an industrial injury date of 2/17/2010. Medical records from 2014 were reviewed. The patient complained of bilateral shoulder pain, rated 6 to 8/10 in severity, and aggravated by activities of daily living. Physical examination of both shoulders showed tenderness and restricted motion. Neer's test was negative. Muscle strength of bilateral upper extremities was graded 4/5. X-ray of the left shoulder, dated 6/13/2014, demonstrated suspected resection of the distal clavicle. MRI of the left shoulder, dated 9/23/13, demonstrated tendinosis of distal infraspinatus tendon. Treatment to date has included left shoulder arthroscopy, subacromial decompression and distal clavicle excision on 1/23/2014, physical therapy, cortisone injection, and medications. Utilization review from 8/27/2014 denied the request for Motorized cold therapy for the left shoulder because there was no recent surgical intervention to warrant this device.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized cold therapy for the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299, 308. Decision based on Non-MTUS Citation Official Disability Guidelines, Motorized Cold Therapy Unit

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

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG) was used instead. ODG recommends continuous-flow cryotherapy as an option after surgery, but not for non-surgical treatment. Postoperative use generally may be up to 7 days, including home use. In this case, patient underwent left shoulder arthroscopy, subacromial decompression and distal clavicle excision on 1/23/2014. He is 8 months status post surgery. There is no clear indication for cold therapy unit at this time. There is no discussion concerning need for variance from the guidelines. Therefore, the request for Motorized cold therapy unit for the left shoulder is not medically necessary.