

Case Number:	CM14-0179577		
Date Assigned:	11/04/2014	Date of Injury:	06/18/2013
Decision Date:	12/15/2014	UR Denial Date:	10/21/2014
Priority:	Standard	Application Received:	10/29/2014

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 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:

27 year old male claimant with an industrial injury dated 06/18/13. MRI of the left shoulder dated 01/27/14 reveals a supraspinatus tendinitis. Exam note 07/02/14 states the patient returns with left shoulder pain. The patient explains that the pain is radiating to the fingers. The patient has difficulty using hand to grasp, and grip. Upon physical exam the patient demonstrated full range of motion with 1+ lateral epicondylar tenderness. The patient is noted to have 4/5 muscle strength on flexion and extension of the wrist with loss of grip and pinch strength. The patient completed a positive Tinel's sign test at the elbow and negative at the wrists. There is a loss of sensation at the left long, ring, and small fingers. The patient was authorized for a left cubital tunnel release on 08/06/14. Exam note 10/10/14 states the patient returns with shoulder sprain/strain. Treatment includes a cold therapy compression device.

IMR ISSUES, DECISIONS AND RATIONALES

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

Intermittent cold therapy limb compression device: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-shoulder chapter

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: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case there is no specification of length of time requested postoperatively for the cryotherapy unit. Therefore the determination is for non-certification.

Wrap for cold unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

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: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case there is no specification of length of time requested postoperatively for the cryotherapy wrap for the unit. Therefore the determination is for non-certification.