

Case Number:	CM14-0021934		
Date Assigned:	05/09/2014	Date of Injury:	10/02/2012
Decision Date:	07/10/2014	UR Denial Date:	02/05/2014
Priority:	Standard	Application Received:	02/21/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in Texas. 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 Physician 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 53 year old male who reported an injury to his right shoulder on 10/02/12. The clinical note dated 12/11/13 indicates the injured worker complaining of right shoulder pain. The injured worker was able to demonstrate 5/5 strength throughout the rotator cuff muscles. The injured worker was able to demonstrate 170 degrees of right shoulder flexion, 90 degrees of external rotation, and 175 degrees of abduction. The MRI of the right shoulder dated 07/22/13 revealed a status post tendon repair. A small focal intersubstance tear was identified at the distal supraspinatus. The clinical note dated 07/08/13 indicates the injured worker able to demonstrate 4+/5 strength with the supraspinatus. Mild discomfort was identified with the infraspinatus strength testing. The injured worker had a mildly positive belly press test and O'Brien's test at that time. The clinical note dated 01/06/14 indicates the injured worker showing no positive findings with provocative testing at the right shoulder. No significant range of motion deficits were identified. The clinical note dated 01/22/14 indicates the injured worker showing a positive O'Brien's test. The injured worker also demonstrated positive Hawkins' and Neer's signs. The note indicates the injured worker utilizing muscle relaxer, Flexeril, at that time. The previous utilization review dated 10/15/13 resulted in a denial for an arthroscopic synovectomy and decompression, twelve postoperative physical therapy sessions, and a cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

DURABLE MEDICAL EQUIPMENT: COLD THERAPY UNIT TO THE RIGHT SHOULDER: 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) Shoulder Chapter, Continuous-flow cryotherapy.

Decision rationale: The request for a durable medical equipment to include a cold therapy unit for the right shoulder is not medically necessary. The documentation indicates the injured worker complaining of right shoulder pain. A continuous cryotherapy/cold unit is indicated at the shoulder provided the injured worker meets specific criteria to include the unit to be used as part of the postoperative treatment for up to seven days as outlined by Official Disability Guidelines (ODG). No information was submitted regarding the injured worker's completion of a recent surgical intervention at the right shoulder. Additionally, no information was submitted regarding the duration of the intended use. Given these factors, this request is not indicated as medically necessary.