

Case Number:	CM14-0025083		
Date Assigned:	06/11/2014	Date of Injury:	04/02/2013
Decision Date:	07/15/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/27/2014

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, has a subspecialty in Pain Medicine 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 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 33 year old male whose date of injury is 04/02/2013. On this date he was grabbed by a student and noted immediate left shoulder pain. Treatment to date includes physical therapy, acupuncture and injection therapy. MRI of the left shoulder dated 12/30/13 revealed no significant internal derangement. Progress note dated 01/20/14 indicates the injured worker sustained injuries to the left shoulder and low back. Assessment notes left shoulder strain and upper back strain. The injured worker was authorized to undergo left shoulder arthroscopy with debridement and capsulorrhaphy with a seven day postoperative rental of a cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

COLD THERAPY UNIT: Upheld

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

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: Based on the clinical information provided, the request for cold therapy unit is not recommended as medically necessary. The injured worker was authorized to undergo left shoulder arthroscopy with debridement and capsulorrhaphy with seven day postoperative rental of a cold therapy unit. The Official Disability Guidelines would support use of a continuous flow cryotherapy unit for up to seven days in the postoperative period, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. There is no postoperative assessment submitted for review. The request as written is not medically necessary.