

Case Number:	CM14-0026729		
Date Assigned:	06/13/2014	Date of Injury:	12/15/2008
Decision Date:	07/17/2014	UR Denial Date:	01/29/2014
Priority:	Standard	Application Received:	03/03/2014

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 Emergency Medicine 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:

The patient has a reported date of injury on 12/15/2008. No mechanism of injury was provided. The patient has a diagnosis of rotator cuff tear with retraction, acromioclavicular joint arthritis and impingement syndrome. Multiple medical records from primary treating physician and consultants reviewed. The last report was available until 1/8/14. Several of the reports by the primary treating physician is hand written and legibility is problematic in several of the provided reports. The last office report was done prior to surgery. The patient reported no change in shoulder pain. Objective exam showed R shoulder pain with palpation. There is a decreased range of motion, positive drop test, Hawkin's test and positive Neer test. Rotator cuff strength is 3/5. The patient had undergone surgery of 1/21/14 with reported full-thickness rotator cuff tear repair of R shoulder, subacromial decompression, partial acromionectomy with bursectomy, debridement of superior labral tear and distal R clavicle resection, synovectomy, bursectomy and intra-operative lidocaine injection of R shoulder. There is no provided post-operative report. The patient had an approved physical therapy after surgery. The medications, imaging and other tests were reviewed but are not relevant to this review. A Utilization review is for cold therapy unit plus pads for 14 days rental for R shoulder (Retrospective). Prior UR on 1/29/14 denies request.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REVIEW FOR COLD THERAPY UNIT PLUS PAD X 14 DAY RENTAL FOR RIGHT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder(Acute and Chronic, Continuous-Flow Cryotherapy).

Decision rationale: The MTUS Chronic Pain and ACOEM guidelines only have vague recommendations concerning icing post surgery and do not provide information to make an evidenced based recommendation. As per Official Disability Guide (ODG), continuous flow cryotherapy is recommended as a post-surgical option as it may decrease inflammation, pain and swelling. ODG only recommends up to 7 days of use. The requested 14 days does not meet ODG recommendations and is not medically necessary.