

Case Number:	CM14-0030254		
Date Assigned:	06/20/2014	Date of Injury:	02/23/2013
Decision Date:	07/17/2014	UR Denial Date:	02/14/2014
Priority:	Standard	Application Received:	03/10/2014

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 Illinois. 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 54 year old male who reported injury to the left shoulder on 02/23/2013 of unknown mechanism. The injured worker complained of and constant pain with no improvement in the left shoulder rating the pain 7-10 on 1-10 scale. Shoulder range of motion on 01/27/2014 was flexion of right 170 degrees, of left 90 degrees; abduction of right 180 degrees, of left 90 degrees; external rotation of right 90 degrees, of left 70 degrees; internal rotation of right 70 degrees, of left 50 degrees; extension of right 50 degrees of left 30 degrees, and adduction of right 40 degrees, of left 10 degrees. There was noted guarding and resisted motion of the left shoulder. A magnetic resonance imaging (MRI) done 10/04/2013 revealed supraspinatus tendinosis with mild bursal surface fraying, interval post-operative changes consistent with biceps tenodesis and labral repair, irregularity of the superior labrum which was likely in combination of postoperative degenerative changes, prominent soft tissue extending along the anterior labrum; however, there had been interval decrease in the degree of infolding within the glenohumeral joint, persistent tear of the posterior labrum; however, there has been interval decrease in size of an adjacent paralabral cyst, 3 mm focal area of decreased signal intensity adjacent to the anterior superior labrum which may be postoperative in nature or may represent a small focal loose body, and interval acromioplasty changes. The injured worker had diagnoses of status post left shoulder superior labral repair, biceps tenodesis, distal clavicle excision (06/08/2013), slower than normal recovery, persistent pain and limited motion, secondary cervical strain, rule out cervicogenic shoulder pain, lumbar sprain/strain, and probable secondary left olecranon bursitis (resolving). He had past treatment of chiropractic therapy, physical therapy, oral medication, electrotherapy, and triggerpoint injections. The injured worker also stated he was applying heat and ice as needed. His medication was naproxen as needed. The treatment plan is for postoperative cold therapy unit, 7 day rental for the left shoulder. The

request for authorization form was not submitted for review. There is rationale for the request for postoperative cold therapy unit, 7 day rental for the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post Operative cold therapy unit, 7 Day Rental for the left shoulder.: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Manipulation under anesthesia, Continuous cryotherapy.

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: The request for postoperative cold therapy unit, 7 day rental for the left shoulder is certified. The injured worker complained of and constant pain with no improvement in the left shoulder rating the pain 7-10 on 1-10 scale. The injured worker had diagnoses of status post left shoulder superior labral repair, biceps tenodesis, distal clavicle excision (06/08/2013), slower than normal recovery, persistent pain and limited motion, secondary cervical strain, rule out cervicogenic shoulder pain, lumbar sprain/strain, and probable secondary left olecranon bursitis (resolving). He had past treatment of chiropractic therapy, physical therapy, oral medication, electrotherapy, and triggerpoint injections. The injured worker also stated he was applying heat and ice as needed. Official disability guidelines (ODG), recommends continuous-flow cryotherapy as an option after surgery, but not for nonsurgical treatment and postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries such as muscle strains and contusions, has not been fully evaluated. Therefore, the request for postoperative cold therapy unit, 7 day rental for the left shoulder is certified.