

Case Number:	CM14-0032492		
Date Assigned:	04/11/2014	Date of Injury:	04/27/2013
Decision Date:	05/28/2014	UR Denial Date:	01/22/2014
Priority:	Standard	Application Received:	02/10/2014

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 Orthopedic Surgery and is licensed to practice in Georgia and 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 an 80-year-old female who reported an injury on 04/27/2013. The mechanism of injury was the injured worker was walking to the stadium with a large crowd when the injured worker was suddenly pushed from behind and fell forward, landing on the ground flat on her stomach. The documentation of 01/06/2014 revealed the injured worker had limited range of motion of the right shoulder with severe tenderness over the coracoacromial ligaments and subacromial space. The supraspinatus isolation was positive. The impingement test and drop arm were positive. The injured worker's diagnosis was rotator cuff of the right shoulder with severe impingement syndrome. The treatment plan included a right shoulder arthroscopic subacromial decompression, an internal medical clearance, postoperative physical therapy and assistant surgeon, a cold therapy unit for 7 days, and transportation to and from the facility as well as a refill of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

COLD THERAPY UNIT RIGHT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 555-556.

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: Official Disability Guidelines recommend continuous flow cryotherapy for up to 7 days postoperatively. The clinical documentation indicated the request was submitted along with a request for a surgical procedure; however, there was lack of documentation indicating the surgical procedure was approved. The request as submitted failed to indicate the duration of care and whether the unit was for rental or purchase. The submitted request additionally failed to indicate whether the unit was for pre-op or post-op use. Given the above, and the lack of clarification, the request for a cold therapy unit for the right shoulder is not medically necessary.