

Case Number:	CM14-0045787		
Date Assigned:	07/02/2014	Date of Injury:	10/25/2013
Decision Date:	08/05/2014	UR Denial Date:	03/28/2014
Priority:	Standard	Application Received:	04/14/2014

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 California and Utah. 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 63-year-old female who reported an injury on 10/25/2013. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to the shoulder. The injured worker was evaluated on 03/06/2014. Physical findings of the right shoulder included tenderness to palpation of the bicipital groove and subacromial bursa, scapular joint tenderness and no evidence of effusion with limited range of motion. It was noted that the injured worker had limited range of motion and a positive impingement sign and a positive O'Brien test. A request was made for a cold therapy unit for the right shoulder and continuous passive motion machine for 14-day rental; however, there was no justification for the request provided within the submitted clinical documentation for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy for the right shoulder, purchase: Upheld

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 chapter.

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 requested cold therapy for the right shoulder, purchase is not medically necessary or appropriate. The clinical documentation submitted for review does not provide any evidence that the injured worker has undergone surgical intervention. The California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines recommend up to a 7-day rental in the postsurgical management of a shoulder injury. However, it is not generally recommended in the absence of surgical intervention. The request exceeds guideline recommendations. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested cold therapy for the right shoulder, purchase is not medically necessary or appropriate.

CPM for 14 day rental for the right shoulder: Upheld

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 chapter.

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 Passive Motion.

Decision rationale: The requested continuous passive motion (CPM) device for 14-day rental for the right shoulder is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines do not recommend the use of this type of intervention unless there is documentation to support the diagnosis of adhesive capsulitis. The clinical documentation submitted for review does not indicate that the patient has adhesive capsulitis that would benefit from this type of intervention. As such, the requested continuous passive motion (CPM) device for 14-day rental for the right shoulder is not medically necessary or appropriate.