

Case Number:	CM14-0054205		
Date Assigned:	07/07/2014	Date of Injury:	02/21/1997
Decision Date:	11/19/2014	UR Denial Date:	04/04/2014
Priority:	Standard	Application Received:	04/23/2014

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 Occupational 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 52 year old male who was injured at work on 02/21/1997. The injured worker is reported to be complaining of left shoulder pain. The pain radiates down his arm. The examination was positive for tenderness along the cuff and biceps of the left shoulder; positive impingement, Hawkin's and Speeds tests. MRI of 02/ 28/14 revealed distal supraspinatus tendinopathy, moderate acromioclavicular degenerative change, and a small subacromial fluid He has been diagnosed of bilateral shoulder impingement status post decompression, lateral epicondylitis, and cubital and carpal tunnel syndrome status post release. His treatments have included Physical therapy, TENS unit, Tramadol and Flexeril. At dispute is the request for 21-day rental of cold therapy unit for the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Twenty-one (21) day rental of a cold therapy unit for the left shoulder post-operatively:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 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 (Acute & Chronic), Continuous-flow cryotherapy

Decision rationale: The injured worker sustained a work related injury on 02/21/1997. The medical records provided indicate the diagnosis bilateral shoulder impingement status post decompression, lateral epicondylitis, and cubital and carpal tunnel syndrome status post release. His treatments have included Physical therapy, TENS unit, Tramadol and Flexeril. The medical records provided for review do not indicate a medical necessity for 21- day rental of cold therapy unit DME Supply or Accessory for the left shoulder. The MTUS makes no reference to cold therapy unit. However the Official Disability Guidelines recommends against it except for a 7 day period after shoulder surgery. Therefore since this is not a postoperative case the requested treatment is not medically necessary and appropriate.