

Case Number:	CM14-0055187		
Date Assigned:	07/07/2014	Date of Injury:	06/26/2012
Decision Date:	08/29/2014	UR Denial Date:	04/17/2014
Priority:	Standard	Application Received:	04/24/2014

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 and Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 31-year-old male was reportedly injured on 6/26/2012. The mechanism of injury was noted as lifting a 70 pound package. The most recent progress note, dated 2/5/2014, indicated that there were ongoing complaints of left shoulder pain with radiation into the arm. Physical examination of the left shoulder demonstrated flexion 100 degrees, abduction 90 degrees, ER 40 degrees, internal rotation 50 degrees, extension 10 degrees and tenderness to posterior aspect of the shoulder, negative Hawkins test, positive drop arm test, positive Yergason's test, positive crossed arm abduction test, 5/5 upper extremity motor strength, upper extremity sensation intact and reflexes 2+ in the upper/lower extremities. MRI of left shoulder, dated 7/24/2012, demonstrated mild rotator cuff strain with mild glenohumeral capsulitis. MR arthrogram of left shoulder, dated 11/11/2013, was negative. Diagnosis was left rotator cuff syndrome. Previous treatment included a left shoulder injection. A request had been made for the purchase or rental of a cold therapy unit for the left shoulder for 7 day use postop for the left shoulder, which was not certified in the utilization review on 4/15/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase or rental of a cold therapy unit for the left shoulder for 7 day use post-op for left 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) Official Disability Guidelines (ODG) ODG -TWC/ODG Integrated Treatment/Disability Duration Guidelines; Shoulder (Acute & Chronic) - Continuous-Flow Cryotherapy (updated 07/29/14).

Decision rationale: MTUS/ACOEM practice guidelines do not address this request. ODG supports continuous-flow cryotherapy in the postoperative setting for shoulder surgery up to 7 days, including home use. Review of the available medical records showed where surgery was recommended, but non-certified. As a special note, there is no documentation of physical therapy and the MR arthrogram of the left shoulder was negative for rotator cuff pathology. In the absence of a postoperative setting, this request is not considered medically necessary.