

Case Number:	CM14-0076140		
Date Assigned:	07/16/2014	Date of Injury:	02/20/2013
Decision Date:	09/22/2014	UR Denial Date:	05/16/2014
Priority:	Standard	Application Received:	05/23/2014

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 Physical Medicine and Rehabilitation 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 55 year old male whose date of injury is 02/20/2013. On this date the injured worker fell on his left arm and sustained injuries to the left shoulder and left finger. Note dated 10/23/13 indicates diagnoses are sprain/strain shoulder, contusion of shoulder, unspecified disorder bursae tendon, and pain in joint shoulder. The injured worker has been authorized for left shoulder arthroscopy, subacromial decompression, debridement of the labrum and rotator cuff repair, left ring finger trigger finger release with cyst excision and seven day rental of cool therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cool Therapy 2 week rental for the 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.

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: Based on the clinical information provided, the request for cool therapy a two week rental for the left shoulder is not recommended as medically necessary. The injured

worker has been authorized for left shoulder arthroscopy, subacromial decompression, debridement of the labrum and rotator cuff repair, left ring finger trigger finger release with cyst excision and seven day rental of cool therapy unit. The Official Disability Guidelines would support continuous flow cryotherapy unit for up to seven days in the postoperative period, and there is no clear rationale provided to support exceeding this recommendation.