

Case Number:	CM14-0003149		
Date Assigned:	01/31/2014	Date of Injury:	06/03/1998
Decision Date:	04/16/2015	UR Denial Date:	12/26/2013
Priority:	Standard	Application Received:	01/09/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 61-year-old female who sustained an industrial injury on 06/03/1998, relative to a fall. Past medical history was positive for diabetes, hypertension and dyslipidemia. The 9/4/12 right shoulder MRI demonstrated partial tearing and delamination of the subscapularis tendon, bicipital issues, and early arthritic changes of the humeral head. The 6/17/13 treating physician report cited right shoulder tenderness over the acromioclavicular joint, pain with cross body abduction, pain and weakness with supraspinatus testing, and positive Yergason's and Speeds tests. Surgery was requested for the right shoulder. An associated request for cold therapy unit for 2 weeks rental was also submitted. The 12/26/13 utilization review non-certified the request for cold therapy unit x 2-week rental as the associated surgery was not certified. The 3/24/14 treating physician report cited grade 7/10 right shoulder pain with difficulty in overhead activities and activities of daily living. She was taking tramadol and Motrin, and physical therapy had not been successful. Physical exam documented shoulder elevation to 115-120 degrees, abduction 90 degrees, external rotation 30 dorsiflexion, and internal rotation to her buttocks/sacroiliac joint. There was supraspinatus weakness, tenderness over the acromioclavicular joint, and pain with cross body abduction. Impingement signs were positive. Right shoulder arthroscopy with rotator cuff repair, biceps tenodesis, and distal clavicle excision was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

One Cold Therapy Machine for Post-Operative use on Right Shoulder (2-week rental):
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Continuous flow cryotherapy.

Decision rationale: The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous-flow cryotherapy is an option for up to 7 days in the post-operative setting following shoulder surgery. Guideline criteria have not been met. There is no compelling reason to support the medical necessity of a cold therapy unit beyond guidelines recommendations. Additionally, there is no documentation in the records that the associated surgery had been found medically necessary. Therefore, this request is not medically necessary.