

Case Number:	CM14-0121618		
Date Assigned:	09/16/2014	Date of Injury:	03/14/2013
Decision Date:	05/22/2015	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/01/2014

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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

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 56 year old male, who sustained an industrial injury on March 14, 2013. The injured worker's initial complaints and diagnoses are not included in the provided documentation. The injured worker was diagnosed as having right shoulder impingement syndrome, right superior labral tear from anterior to posterior tear, and right shoulder acromioclavicular joint osteoarthritis. Diagnostics to date has included MRI. Treatment to date has included physical therapy, chiropractic therapy, acupuncture, a right shoulder steroid injection, and non-steroidal anti-inflammatory medications. On July 15, 2014, the injured worker complains of continued right shoulder pain and weakness, which is worse with overhead work. The physical exam revealed tenderness over the deltoid complex and the acromioclavicular joint of the right shoulder. There was decreased muscle strength with range of motion and decreased range of motion due to pain. The treatment plan includes a post-operative cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post Operative Cold Therapy Unit: 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: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

Decision rationale: The ACOEM Chapter 9 on Shoulder Complaints indicates that specialized treatments or referrals require a rationale for their use. According to the documents available for review, there is no rationale provided to support the use of a cold therapy unit. Therefore at this time the requirements for treatment have not been met, and medical necessity has not been established.