

Case Number:	CM14-0026866		
Date Assigned:	06/13/2014	Date of Injury:	10/08/2012
Decision Date:	02/23/2015	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	03/03/2014

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: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabn, 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 48-year-old male who reported an injury on 10/08/2012. The mechanism of injury reportedly occurred while repetitively carrying and lifting heavy liquids. His diagnoses include complete rupture of rotator cuff, adhesive capsulitis of shoulder, articular cartilage of shoulder region, occipital tenosynovitis, and contracture of tendon. His past treatments included postoperative ice machine and physical therapy. Diagnostic studies included an MRI of the left shoulder dated 01/02/2013. His pertinent surgical history includes a left shoulder open rotator cuff repair on 04/16/2013 and a left shoulder arthroscopic extensive debridement, arthroscopic subacromial decompression, and arthroscopic distal clavicle excision on 08/08/2013. The injured worker presented on 01/02/2015 with complaints of neck, upper back, left anterior/posterior shoulder, and numbness and tingling down into the left arm and into the fingers. He reported that the pain occurred 60% of the time and that the pain was made worse with head movement. He rated the pain at 4/10 to 4/10. On physical examination of the cervical spine, flexion was at 50 degrees, extension was at 50 degrees, left lateral flexion was at 30 degrees, right lateral flexion was at 40 degrees, left rotation was at 65 degrees, and right rotation was at 70 degrees. The injured worker had a positive shoulder decompression test on the left and hyperextension test on the left. The range of motion to the thoracic spine in flexion was at 50 degrees, left rotation 25 degrees, and right rotation was at 30 degrees. His current medications include clonazepam, ibuprofen, fluticasone, citalopram, and Percocet since at least 01/12/2015. The treatment plan included no lifting or carrying over 10 pounds, and no pushing, pulling or over head work. The rationale for the request was not provided within the documentation

submitted for the review. The Request for Authorization Form was not provided within the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ice machine rental x 15 days: 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 (Acute & Chronic), Continuous-flow cryotherapy

Decision rationale: The request for ice machine rental x 15 days is not medically necessary. The injured worker has neck, shoulder, and low back pain. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use may generally be up to 7 days including home use. The documentation submitted for review provides evidence that the patient was previously authorized for postoperative use of continuous flow cryotherapy for 7 days. Additionally, the documentation submitted for review does not provide any indication of current surgery indicating the need for postoperative use of current continuous flow cryotherapy. Additionally, number of days requested exceeds the guideline recommendations. As such, the request for ice machine rental x 15 days is not medically necessary.