

Case Number:	CM15-0003776		
Date Assigned:	01/14/2015	Date of Injury:	08/19/2003
Decision Date:	03/09/2015	UR Denial Date:	12/26/2014
Priority:	Standard	Application Received:	01/08/2015

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

Certification(s)/Specialty: Emergency Medicine

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 was a 59 year old female, who sustained an industrial injury, August 9, 2003. The injured worker had two motor vehicle accidents which caused the disability. The injured worker's chief complaint was right shoulder pain with decreased range of motion and strength. The injured worker was diagnosed with adhesive capsulitis of the shoulder, brachial neuritis or radiculitis, carpal tunnel syndrome, massive right rotator cuff tear, right shoulder impingement and degenerative arthropathy. The injured worker's treatment included diagnostic testing, muscle relaxants, MRI for the right shoulder, physical therapy, medications, and right shoulder surgery after the first injury and home exercises. On December 8, 2014, the primary treating physician requested cold therapy for 14 days for right shoulder postoperative care for pain relief. On December 26, 2014, the UR denies authorization for cold therapy for 14 days. The denial was based on the ODG guidelines Shoulder chapter. Postoperative use generally maybe up to 7 days, including home use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy unit Qty:14: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Shoulder Chapter, Rotator Cuff Syndrome/Impingement Syndrome

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder, Continuous Flow Cryotherapy

Decision rationale: The requested cold therapy unit for 14 days, is not medically necessary. CA MTUS is silent on this issue and ODG, Shoulder, Continuous Flow, Cryotherapy, recommends up to 7 days post-op cold therapy. In a post-operative setting, cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. On December 8, 2014, the primary treating physician requested cold therapy for 14 days for right shoulder postoperative care for pain relief. The treating physician did not document the medical necessity for post-op cold therapy beyond the referenced guideline recommendations of seven days usage. The criteria noted above not having been met, cold therapy unit for 14 days is not medically necessary.