

Case Number:	CM15-0004481		
Date Assigned:	01/15/2015	Date of Injury:	09/23/2009
Decision Date:	03/24/2015	UR Denial Date:	12/22/2014
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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 reported an injury on 09/23/2009. The mechanism of injury was a fall. His diagnoses include status post left shoulder surgery. Past treatments were noted to include surgery and medication. The injured worker underwent a left shoulder debridement of rotator cuff and labrum, synovectomy with capsular release, a distal clavicle resection, and subacromial decompression on 12/04/2014. On 12/10/2014, it was indicated the injured worker had intermittent pain that he rated 1/10 to 2/10 with the use of medication. Upon physical examination, it was indicated the injured worker had decreased range of motion to the left shoulder measuring flexion at 90 degrees, abduction at 80 degrees, and external rotation at 50 degrees. His strength measured 4/5 throughout. Relevant medications were noted to include Percocet. The treatment plan was noted to include a home exercise program, therapy, heat and cold modalities, and a cortisone injection. A request was received for S4-INF for the left shoulder, thirty day rental and for garment purchase for the left shoulder without a rationale.

IMR ISSUES, DECISIONS AND RATIONALES

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

S4-INF for the left shoulder, thirty day rental: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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: According to the Official Disability Guidelines, continuous flow cryotherapy is recommended postsurgically for the shoulder and not to exceed 7 days. The clinical documentation submitted for review indicated the injured worker had surgical procedure done to the shoulder; however, the request exceeds the guidelines recommended duration of treatment and there is no rationale for the requested service. Consequently, the request is not supported by the evidence based guidelines. As such, the request for S4-INF for the left shoulder, thirty day rental is not medically necessary.

Garment purchase for the left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.