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| Case Number: | CM15-0105618 | | |
| Date Assigned: | 06/10/2015 | Date of Injury: | 06/06/2013 |
| Decision Date: | 07/10/2015 | UR Denial Date: | 05/05/2015 |
| Priority: | Standard | Application Received: | 06/01/2015 |

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: 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:

This injured worker is a 49-year-old female who sustained an industrial injury on 6/6/13. Injury occurred when she picked up an equipment bag weighing 30 pounds and heard a pop in her right shoulder. Past surgical history was positive for right shoulder arthroscopy with extensive intra-articular debridement, subacromial decompression, and biceps tenodesis on 10/7/13. The 6/18/14 right shoulder MR arthrogram impression documented a high grade partial thickness tear of the 90% of the fibers of the supraspinatus at the footprint with 12 mm retraction of the fibers. There were post-surgical changes to the labrum with evidence of a labral tear at the base of the glenoid labrum involving the posterosuperior, superior, and anterosuperior aspects. There was full thickness cartilage loss throughout the glenoid. There was low-grade partial thickness tearing of the infraspinatus at the footprint and prior biceps tenodesis. The 4/22/15 treating physician report cited continued right shoulder pain that frequently woke her. Pain was worse with activity, and relief with home exercise and medications. Right shoulder exam documented tenderness over the subacromial region, acromioclavicular joint, and periscapular musculature with spasms. Impingement, cross arm, and Codman's drop arm tests were positive. There was global 4/5 right shoulder weakness. Authorization was requested for right shoulder arthroscopy with subacromial decompression, acromioplasty, resection of the coracoacromial ligament and bursa, distal clavicle excision, and open rotator cuff repair, and associated surgical requests. The 5/5/15 utilization review certified a request for right shoulder arthroscopy with subacromial decompression, acromioplasty, resection of the coracoacromial ligament and bursa, distal clavicle excision, and open rotator cuff repair. Two associated surgical requests were submitted

for a cold therapy unit, one for 7 days use which was certified consistent with guidelines, and a second one for indefinite use which was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: cold therapy unit (indefinite use): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation, 9th edition (web).

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. The 5/5/15 utilization review decision recommended certification of a cold therapy unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.