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| Case Number: | CM15-0133433 | | |
| Date Assigned: | 07/21/2015 | Date of Injury: | 01/06/2015 |
| Decision Date: | 08/18/2015 | UR Denial Date: | 06/15/2015 |
| Priority: | Standard | Application Received: | 07/10/2015 |

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: North Carolina

Certification(s)/Specialty: Family Practice

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 50 year old female, who sustained an industrial injury on 1/6/2015. The mechanism of injury was a trip and fall. The injured worker was diagnosed as having left sided cervical 6-7 radiculopathy and left shoulder greater tuberosity fracture mal-union with severe range of motion loss. Left shoulder magnetic resonance imaging showed a partial nonunion fracture of the lateral humeral head and partial avulsion. Treatment to date has included sling, occupational therapy and medication management. In a progress note dated 5/29/2015, the injured worker complains of cervical and left shoulder pain. Physical examination showed generalized left shoulder pain with decreased range of motion. Treatment plan included a subacromial decompression. The treating physician is requesting Ultra sling cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: Ultrasling and 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, Shoulder chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) cryotherapy.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. The ACOEM does recommend the at home local application of cold packs the first few days after injury and thereafter the application of heat packs. The Official Disability Guidelines section on cryotherapy states: Recommended as an option after surgery but not for non-surgical treatment. The request is for post-surgical use however, the time limit for request is in excess of recommendations. Per the ODG, cold therapy is only recommended for 7 days post operatively. The request is in excess of this amount and therefore is not certified.