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| Case Number: | CM15-0141472 | | |
| Date Assigned: | 08/06/2015 | Date of Injury: | 01/01/2011 |
| Decision Date: | 09/25/2015 | UR Denial Date: | 07/06/2015 |
| Priority: | Standard | Application Received: | 07/20/2015 |

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, Oregon, Washington
 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:

The injured worker is a 39 year old female who sustained an industrial injury on 01-01-2011. Mechanism of injury occurred from repetitive duties. Diagnoses include bilateral bicipital tendonitis and impingement syndrome with narrowing of the proximal and distal coracoacromial arch. Treatment to date has included diagnostic studies, medications, physical therapy, and cortisone injections. She is status post bilateral carpal tunnel release and cubital tunnel releases. A physician progress note dated 06-26-2015 documents the injured worker complains of bilateral shoulder pain. On examination there is pain with range of motion. She has a positive O'Brien's, Neer's and Hawking's. Rotator cuff strength is diminished. A Magnetic Resonance Imaging of the right shoulder done on 04-16-2014 noted acromioclavicular joint arthropathy with narrowing of the proximal and distal coracoacromial arch and there is also inflammation-tenosynovitis of the biceps. The treatment plan includes right shoulder arthroscopy, subacromial decompression, Mumford procedure and associated surgical service: Shoulder immobilizer. Treatment requested is for associated surgical service: Cold therapy purchase.

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 purchase: 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 Chapter, Continuous flow cryotherapy.

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case there is no specification of length of time requested postoperatively for the cryotherapy unit. Additionally there is no indication for a cold therapy purchase. Therefore the determination is for non-certification, therefore is not medically necessary.