

Case Number:	CM15-0191548		
Date Assigned:	10/05/2015	Date of Injury:	04/04/2014
Decision Date:	11/10/2015	UR Denial Date:	09/21/2015
Priority:	Standard	Application Received:	09/29/2015

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: Montana, Oregon, Idaho
 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 44 year old male, who sustained an industrial injury on 04-04-2014. The injured worker is currently able to return to modified duty as of 08-05-2015. Medical records indicated that the injured worker is undergoing treatment for right shoulder-arm sprain. Treatment and diagnostics to date has included steroid injections, surgeries, physical therapy, and medications. Current medications include Norco, Advil, Ativan, Soma, Omeprazole, and Lidocaine patches. After review of progress notes dated 08-05-2015 and 08-31-2015, the injured worker reported right shoulder pain and stiffness. Objective findings included decreased right shoulder range of motion with tenderness and pain. The Utilization Review with a decision date of 09-18-2015 modified the request for an associated surgical service: cold therapy unit (purchase) to cold therapy unit rental for seven (7) days. Right shoulder hemi-arthroplasty already approved.

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 purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Continuous Flow Cryotherapy.

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

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 the request is for purchase of a cryotherapy unit and exceeds the guidelines recommendation of 7 days. Therefore the request is not medically necessary.