

Case Number:	CM15-0028281		
Date Assigned:	02/20/2015	Date of Injury:	03/15/2010
Decision Date:	04/14/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/16/2015

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: Minnesota, Florida
 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 43-year-old male, who sustained an industrial injury on 03/15/2010. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. Diagnoses include bilateral carpal tunnel syndrome, status post bilateral carpal tunnel endoscopic release, lumbar spine strain/sprain with disc protrusion at lumbar four to five, and bilateral shoulder impingement, and status post left shoulder arthroscopy. Treatment to date has included shoulder injection, home exercise program, medication regimen, above listed surgeries, and physical therapy. In a progress note dated 01/15/2015, the treating provider reports less left shoulder pain, ongoing right shoulder pain, neck pain and pressure, and low back pain that radiates to the right lower extremity with numbness to the right thigh. Surgery for the right shoulder has been requested but the records do not indicate certification of the requested surgery. The treating physician requested one cold therapy unit for post-operative use after a request for right shoulder arthroscopy with subacromial decompression, mumford procedure, and labral debridement. On 01/28/2015, Utilization Review non-certified the requested cold therapy unit times seven days for the right shoulder as an outpatient between 01/20/2015 and 03/06/2015, noting that the surgical procedure had not been certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy Unit x 7 days for the Right Shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Shoulder, Table 2, Summary of Recommendations, Shoulder Disorders and on the Official Disability Guidelines, Shoulder (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Continuous flow cryotherapy.

Decision rationale: Primary treating physician's progress report dated January 15, 2015, indicates a request for right shoulder arthroscopy with subacromial decompression, Mumford procedure and debridement of the labral tear. The available documentation indicates that the requested surgical procedure for the right shoulder has not been certified. This independent medical review pertains to the request for postoperative cold therapy unit rental for 1 week which was noncertified by utilization review as the surgical procedure had not been certified. ODG guidelines recommend postoperative use of continuous flow cryotherapy for 7 days after shoulder surgery. It reduces pain, swelling, and inflammation and also reduces the need for narcotics after surgery. The request for postoperative use for 7 days is appropriate and supported by guidelines. However, in the absence of documented approval of the surgical procedure, the medical necessity of the postoperative continuous flow cryotherapy unit is also not supported and as such, the request for the 7 day rental of the cold therapy unit is not medically necessary.