

Case Number:	CM15-0034914		
Date Assigned:	03/25/2015	Date of Injury:	10/10/2013
Decision Date:	05/01/2015	UR Denial Date:	02/23/2015
Priority:	Standard	Application Received:	02/24/2015

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 (IW) is a 51 year old female, who sustained an industrial injury on 10/10/2013. She has reported pain in the right shoulder, wrist and hand. The diagnoses have included status post right thumb trigger finger release 4/24/2014, with residual contracture, right upper extremity overuse syndrome, tendonitis, shoulder sprain/strain, and right shoulder impingement syndrome with calcific deposits. Treatment to date has included medication therapy, physical therapy, joint injections and rest. Failure of conservative treatment is documented and surgical criteria have been met. Currently, the IW complains of severe pain and grinding of the right shoulder. The physical examination from 1/21/15 documented a positive impingement sign, tenderness and weakness in the right shoulder. The plan of care included arthroscopy of the right shoulder with acromioplasty and removal of the calcific deposits. Surgery has been certified. The disputed issue pertains to a modified request for purchase of a postoperative cold therapy unit.

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-Treatment in Workers' Compensation (ODG-TWC), Shoulder chapter.

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: ODG guidelines recommend postoperative use of continuous flow cryotherapy after shoulder surgery. The usual recommended duration of use is 7 days. It reduces pain, swelling, inflammation, and also reduces the postoperative need for narcotics. Use beyond 7 days is not recommended. As such, the request for purchase of the unit is not supported and the medical necessity of the request has not been substantiated.