

Case Number:	CM15-0046775		
Date Assigned:	03/19/2015	Date of Injury:	11/27/2012
Decision Date:	05/01/2015	UR Denial Date:	03/10/2015
Priority:	Standard	Application Received:	03/12/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 23 year old male who sustained a work related injury November 27, 2012. While reaching overhead for a heavy box, he hyperextended and injured his left shoulder. He developed immediate pain in the anterior aspect of the left shoulder. He was first treated with conservative modalities (unspecified) and then provided with a series of two cortisone injections; the first with some pain relief the second no pain relief. Past history included esophageal stent placement and removal for eosinophilic esophagitis, migraine headaches, and s/p left shoulder arthroscopic surgery November, 2013. According to a physician's office visit, dated February 20, 2015, the injured worker presented with continued pain of the left shoulder, rated 5/10. He continues with home exercise despite the pain and was taking naproxen sodium and Norco. Impression is documented as progressive left shoulder arthrofibrosis/adhesive capsulitis with recurrent impingement with long head of biceps tendinitis. Diagnoses included other affections shoulder region; rotator cuff sprain and strain; adhesive capsulitis of shoulder. Treatment plan after discussion was to proceed with left shoulder arthroscopy and bursoscopy, redo capsular release, possible redo decompression, excision capture lesions and correction and pre and post-operative instructions reviewed. On March 3, 2015, the injured worker underwent a diagnostic arthroscopy and bursoscopy with labral debridement, subacromial bursectomy, debridement of bursal scuff lesion of rotator cuff, and excision of capture lesions in the posterior subacromial space, mini posterior capsular release, subacromial decompression with excision of the CA ligament and injection of the left glenohumeral joint and left subacromial space with Marcaine.

Immediate range of motion exercise was initiated and he was scheduled for formal physical therapy March 4, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold compression system & supplies: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Procedure Summary.

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

Decision rationale: The official disability guidelines recommends postoperative use of continuous flow cryotherapy to help reduce pain, inflammation, swelling, and medication usage, however its usage is indicated for the first seven days of the postoperative period. The injured employee underwent a right shoulder surgery March 3, 2015 and this request does not indicate that it is retrospective. Furthermore, it is also not stated if this is for a rental or purchase and should be for a rental for seven days time. For these reasons, this request for a cold compression system and supplies is not medically necessary.

Wrap: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Procedure Summary.

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

Decision rationale: The official disability guidelines recommends postoperative use of continuous flow cryotherapy to help reduce pain, inflammation, swelling, and medication usage, however its usage is indicated for the first seven days of the postoperative period. The injured employee underwent a right shoulder surgery March 3, 2015 and this request does not indicate that it is retrospective. Furthermore, it is also not stated if this is for a rental or purchase and should be for a rental for seven days time. For these reasons, this request for a cold compression wrap is not medically necessary.