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| Case Number: | CM15-0057167 | | |
| Date Assigned: | 04/02/2015 | Date of Injury: | 06/25/2013 |
| Decision Date: | 05/05/2015 | UR Denial Date: | 03/02/2015 |
| Priority: | Standard | Application Received: | 03/25/2015 |

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: Illinois, California, Texas
 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 55-year-old female who sustained an industrial injury on 6/25/13. Injury occurred when he was opening a stockroom door and a metal ladder fell, hitting her right shoulder and middle finger. The 11/6/13 right shoulder MRI documented a small high-grade, near full thickness tear of the supraspinatus insertion laterally with underlying tendinosis of the entire supraspinatus tendon. There was moderate degenerative joint disease at the acromioclavicular joint with some subchondral cystic changes. The 2/23/15 treating physician report cited continued right shoulder pain with activity, especially overhead reaching and reaching backwards. Physical exam documented limited range of motion, positive supraspinatus and O'Brien's tests, tenderness over the acromioclavicular joint, sign abduction and flexion weakness, and positive impingement test. Authorization was requested for right shoulder arthroscopic rotator cuff debridement/repair, possible distal clavicle resection, subacromial decompression, and SLAP lesion debridement/repair, pre-operative clearance, cold therapy unit, and immobilizer/sling with pillow, post-op physical therapy, and post-op pain medications. Records indicated that the request for right shoulder surgery was authorized. The 3/02/15 utilization review modified the request for cold therapy unit purchase to a 7-day rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post op 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 Guideline.

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 California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. The 3/02/15 utilization review decision modified a request for purchase of a cold therapy unit to 7-day rental. There is no compelling reason in the records reviewed to support the medical necessity of a cold therapy unit beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.