

Case Number:	CM15-0059936		
Date Assigned:	04/06/2015	Date of Injury:	10/01/2014
Decision Date:	05/12/2015	UR Denial Date:	03/16/2015
Priority:	Standard	Application Received:	03/30/2015

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 66-year-old female who sustained an industrial injury on 10/01/14. Injury was reported relative to her repetitive work duties as a lab technician. Past medical history was positive for hypertension, hyperlipidemia and diabetes mellitus. The 12/14/14 MRI demonstrated a full thickness rotator cuff tear, biceps tendinosis, chronic degenerative labral tearing, and moderate acromioclavicular joint arthrosis with type 2 acromion. The 3/4/15 treating physician report cited continued grade 6/10 right shoulder posterolateral pain. Pain was exacerbated by overhead activity and had been refractory to comprehensive conservative treatment. There was marked loss of range of motion and positive impingement and labral testing. Authorization was requested for right shoulder arthroscopy, possible subacromial decompression, distal clavicle resection, labral repair, biceps tenodesis, and rotator cuff repair. Associated requests included a cold therapy unit x 14 day rental with pad, an Ultrasling, 12 visits of post-operative physical therapy, and an assistant surgeon. The 3/16/15 utilization review certified the request for right shoulder arthroscopic surgery and associated requests for an Ultrasling, 12 visits of post-operative physical therapy, and an assistant surgeon. The request for 14-day rental of a cold therapy unit was modified to 7-day rental of a cold therapy unit consistent with the Official Disability Guidelines.

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 with pad 14 day rental for right shoulder:
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 3/16/15 utilization review decision modified the request for 14-day rental of cold therapy unit to 7-day rental. There is no compelling reason in the records reviewed to support the medical necessity of a cold device beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.