

Case Number:	CM15-0085910		
Date Assigned:	05/08/2015	Date of Injury:	12/26/2013
Decision Date:	06/11/2015	UR Denial Date:	04/24/2015
Priority:	Standard	Application Received:	05/05/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 52 year old male who sustained an industrial injury on 12/26/13 injuring his left shoulder while pulling on a diesel hose. He experienced immediate pain to his left shoulder. He currently has aching, stabbing pain of the left shoulder. His pain level is 6-7/10 without medication and 5-6/10 with medication. His pain is worse with lifting and moving the shoulder backwards and better with ice and medications. He takes Relafen. On physical exam of the left shoulder he exhibits tenderness to palpation at the anterior shoulder and increased pain at abduction and external rotation. He has positive Hawkins and Neer's sign. Diagnoses include left shoulder pain; left shoulder tear of the glenoid labrum; left rotator cuff impingement and acromioclavicular joint arthrosis; chronic pain syndrome; myalgia. Treatments to date include physical therapy, which provided minimal relief of pain; steroid injection without significant effect on pain; home exercise program. Diagnostics include MRI of the left shoulder (1/22/14) showing a tear or fraying of the superior glenoid labrum; left shoulder x-ray showing type II acromion. On 4/14/15 the treating provider requested a cold therapy unit for the left shoulder along with surgical intervention request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of cold therapy unit for left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Partial Claviclectomy, Continuous Flow Cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, pages 909-910.

Decision rationale: Regarding Cold therapy, guidelines state it is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. The request for authorization does not provide supporting documentation beyond the guidelines criteria. There is no documentation that establishes medical necessity or that what is requested is medically reasonable outside recommendations of the guidelines. The request for the unit does not meet the requirements for medical necessity. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post surgery; however, limits the use for 7-day post-operative period as efficacy has not been proven after. The Purchase of cold therapy unit for left shoulder is not medically necessary and appropriate.