

Case Number:	CM15-0087830		
Date Assigned:	05/12/2015	Date of Injury:	06/14/2014
Decision Date:	06/23/2015	UR Denial Date:	04/07/2015
Priority:	Standard	Application Received:	05/07/2015

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: Emergency Medicine

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 53 year old male, who sustained an industrial injury on June 14, 2014. The injured worker's initial complaints and diagnoses are not included in the provided documentation. The injured worker was diagnosed as having impingement syndrome with internal derangement of the right shoulder. Diagnostic studies to date have included an MRI of the right shoulder, which revealed a partial thickness intrasubstance tear of the supraspinatus with impingement pattern of the glenohumeral effusion and a subchondral focal area of increased intensity within the humeral head, rule out chondral lesion. Treatment to date has included steroid injections, physical therapy, and medications. On March 9, 2015, the injured worker complains of constant right shoulder pain with numbness and tingling up into the neck and down to the hands. His pain is rated 9/10. The physical exam revealed tenderness of the coraco-acromial ligament and subacromial, and positive supraspinatus isolation, anterior labral sign, and impingement test. There was limited cervical spine range of motion, positive compression and Spurling's tests, and weakness of the deltoid and wrist extensor muscles. The injured worker was temporarily totally disabled. The treatment plan includes a right shoulder arthroscopy and a cold therapy unit. The requested treatments are a compression wrap and a cold wrap.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold wrap: 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Continuous Flow Cryotherapy.

Decision rationale: The requested Cold wrap, is not medically necessary. CA MTUS is silent on this issue and Official Disability Guidelines, Shoulder, Continuous Flow Cryotherapy, recommends up to 7 days post-op cold therapy. In a post-operative setting, cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The injured worker has constant right shoulder pain with numbness and tingling up into the neck and down to the hands. His pain is rated 9/10. The physical exam revealed tenderness of the coracoacromial ligament and subacromial, and positive supraspinatus isolation, anterior labral sign, and impingement test. There was limited cervical spine range of motion, positive compression and Spurling's tests, and weakness of the deltoid and wrist extensor muscles. The injured worker was temporarily totally disabled. The treatment plan includes a right shoulder arthroscopy and a cold therapy unit. The treating physician did not document the medical necessity for continued use of cold or compression therapy beyond the guideline recommended seven days usage. The criteria noted above not having been met, Cold wrap is not medically necessary.

Compression wrap: 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Continuous Flow Cryotherapy.

Decision rationale: The requested Compression wrap, is not medically necessary. CA MTUS is silent on this issue and Official Disability Guidelines, Shoulder, Continuous Flow Cryotherapy, recommends up to 7 days post-op cold therapy. In a post-operative setting, cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The injured worker has constant right shoulder pain with numbness and tingling up into the neck and down to the hands. His pain is rated 9/10. The physical exam revealed tenderness of the coracoacromial ligament and subacromial, and positive supraspinatus isolation, anterior labral sign, and impingement test. There was limited cervical spine range of motion, positive compression and Spurling's tests, and weakness of the deltoid and wrist extensor muscles. The injured worker was temporarily totally disabled. The treatment plan includes a right shoulder arthroscopy and a cold therapy unit. The treating physician did not document the medical necessity for continued use of cold or compression therapy beyond the guideline recommended seven days usage. The criteria noted above not having been met, Compression wrap is not medically necessary.

