

Case Number:	CM14-0118541		
Date Assigned:	08/06/2014	Date of Injury:	03/26/2012
Decision Date:	10/08/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	07/28/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Sports Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 48-year-old female who reported an injury on 03/26/2012, while she was picking up ammo boxes of venipuncture equipment and sustained an acute onset of pain to the right elbow lateral aspect and left shoulder anterior aspect. The injured worker had a history of left shoulder pain and right elbow pain. The diagnoses included left shoulder bursitis/impingement, left shoulder adhesive capsulitis, moderate symptomatic AC degenerative joint disease, and complete tear with retraction of the supraspinatus and right elbow lateral epicondylitis. Past treatments included physical therapy, medication and corticosteroid injections. The prior surgery included a left arthroscopic shoulder debridement and decompression of the subacromial space. The MRI of the left shoulder dated 09/18/2012 revealed a complete tear to the supraspinatus tendon with an 11.5 mm tendinous retraction, infraspinatus tendinitis and acromioclavicular osteoarthritis. The physical findings dated 04/16/2014 revealed no swelling, deformity or effusion, no abrasions, lacerations or skin break down, active range of motion, flexion was 16 degrees with extension of 60 degrees. Tenderness to palpation at the SAB and supraspinatus tendon. Stability revealed instability with manipulation or weight bearing. The Neer's was positive, Hawkin's positive, Yergason's was negative, Speed's negative, and O'Brien's negative. Strength was 5/5. Sensation normal to the radial, medial ulnar and axillary nerves. Deep tendon reflexes were 2+. The examination of the right elbow revealed active range of motion with flexion at 150 degrees and extension at 0 degrees. No tenderness to palpation on any ligament, tendon or bone structure. No pain with range of motion. No noted instability with manipulation or weight bearing. Strength was 5/5. The treatment plan included weight bearing as tolerated, full range of motion, sling, and medication, therapy included ice therapy, cold therapy for postoperative pain and swelling times 6 weeks, chiropractic therapy with postoperative left shoulder 2 times a week times 6 weeks, and

a left shoulder ASAD and rotator cuff repair. The Request for Authorization dated 08/06/2014 was submitted with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for postoperative rental of cold therapy compression unit, QTY: 6 weeks, beginning on the service date of 04/17/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cold Therapy Unit

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

Decision rationale: The Retrospective request for postoperative rental of cold therapy compression unit, QTY: 6 weeks, beginning on the service date of 04/17/2014 is not medically necessary. The California MTUS/ACOEM did not address. The Official Disability Guidelines do not recommended in the shoulder, as there are no published studies. It may be an option for other body parts. The request was not specific on what body part the cold compression therapy unit was to be used for and it is not recommended for the shoulder. As such, the request is not medically necessary.