

Case Number:	CM14-0143545		
Date Assigned:	09/12/2014	Date of Injury:	03/03/2014
Decision Date:	10/10/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	09/04/2014

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 Family 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:

This injured worker's date of injury is 03/03/2014. This patient receives treatment for persisting right shoulder pain, which arose because of her work. Medical diagnoses include osteoarthritis of the shoulder, shoulder bursitis, bicipital tenosynovitis, supraspinatus strain, and glenoid labrum detachment. On exam right shoulder, ROM is reduced and the Hawkins test is positive, as is the cross arm test. A shoulder MRI on 06/09/2014 shows tearing of the supra- and infraspinatus tendons. The patient received physical therapy and Norco, Soma, and Tramadol for pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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

Decision rationale: The patient had Right Shoulder Arthroscopy with Subacromial Decompression. This review is for a Cold Therapy Unit. The physician requesting the cold therapy unit does not specify the length of time for the treatment. Treatment guidelines call for

up to 7 days of treatment postoperatively. Based on the documentation, the request for a CTU is not medically necessary.