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| Case Number: | CM14-0182919 | | |
| Date Assigned: | 11/07/2014 | Date of Injury: | 02/27/2014 |
| Decision Date: | 12/16/2014 | UR Denial Date: | 10/21/2014 |
| Priority: | Standard | Application Received: | 11/03/2014 |

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 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 patient is a 54-year-old female with a 02/27/14 date of injury, rear-ended in a motor vehicle accident. Diagnoses were traumatic right shoulder impingement syndrome with severe tendonitis, bursitis, tendinitis of the biceps tendon in the groove, tendinitis of the infraspinatus tendon, osteoarthritis of the right acromioclavicular joint, and history of radiculitis. The 10/08/14 Progress report documented that the patient had pain in the cervical spine with right arm radicular pain. The right shoulder pain had been making the patient miserable because she could not do household activities and activities of daily living are affected. She had right shoulder pain on any attempts at heavy lifting. Clinically, there was significant tenderness to palpation over the right shoulder at the subacromial region. There was localized tenderness over the acromioclavicular joint. Range of motion was decreased. Neer's and thumbs down tests were positive. The treatment plan included cortisone injection in the right shoulder which provided relief, arthroscopic right shoulder examination, arthroscopic surgery with synovectomy of biceps tendon as may be necessary including Mumford procedure. She had exhausted and failed her conservative care. Prescribed medications were Tramadol and Motrin. Acupuncture and cervical ESIs were also recommended. She remained on temporary total disability. The 10/08/14 request for authorization documented the request for arthroscopic examination of the right shoulder, decompression, Mumford, biceps synovectomy, medical clearance, sling, cold, and postop PT.04/22/14 MRI of the right upper extremity showed severe tendinosis of supraspinatus tendon, tendinosis of the subscapularis and infraspinatus tendons, type II acromion with moderately severe degenerative changes in the right acromioclavicular joint, biceps tendinitis, a 15-mm cyst in the tuberosity of the humerus, and right shoulder joint effusion. The 02/27/14 x-rays of the right shoulder showed probable grade 1 acromioclavicular separation and a 1.5 cm subchondral

cyst in the humeral head commonly associated with rotator cuff tears. Treatment to date has included medications, physical therapy, and shoulder injection.

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: 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 Non-MTUS Official Disability Guidelines (ODG) Shoulder, Continuous-Flow Cryotherapy.

Decision rationale: Medical necessity has not been established for associated surgical service: cold therapy unit. The patient has right shoulder pain and has a request for right shoulder arthroscopy with synovectomy of biceps tendon as may be necessary including Mumford procedure. The cold therapy unit is to be used postoperatively. However, there is no discussion whether the request is for a purchase or a rental. If it is a rental, the duration of use has not been specified. ODG recommends the postoperative use of a cold therapy unit for up to 7 days. The request is not supported due to lack of documentation. Therefore the request is not medically necessary.