MAXIMUS Federal Services

Case Number:	CM14-0021043		
Date Assigned:	02/21/2014	Date of Injury:	04/10/1995
Decision Date:	06/24/2014	UR Denial Date:	12/20/2013
Priority:	Standard	Application Received:	01/09/2014

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 Orthopaedic Surgery and is licensed to practice in Mississippi. 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 57-year-old male with a date of injury of April 10, 1995. An original mechanism of injury described was a crush injury to the right thumb. The injured worker underwent surgical treatment for the fracture and in 2007 a neuroma was removed from this injury. A 2nd injury was reported and reportedly due to repetitive lifting in 2000. This injury resulted in head, neck, and upper extremity complaints to the hands, elbows, and shoulders bilaterally. Physical examination supports a diagnosis of acromioclavicular arthritis and impingement. A diagnostic/steroid injection into the subacromial space was performed with dramatic improvement. An MRI from August 2013 demonstrates supraspinatus tendinosis, bicipital tendinosis, subacromial bursitis, and degenerative changes of acromioclavicular (AC) joint, and a subchondral cystic lesion in the lateral aspect of the humeral head. An outpatient right shoulder subacromial decompression is requested with a preoperative medical clearance, pain pump, a sling, and postoperative cryotherapy device.

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: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The medical treatment guidelines support the use of cold therapy devices in select clinical settings including the postoperative period following shoulder surgeries. The guideline consensus, based on evidence based studies, is the support of the use of this device for up to seven days following surgery. The request is for a cold therapy unit. It appears this request is for the purchase of the units. When noting that there is no guideline support for the purchase of this unit for the proposed surgical procedure, there would be no clinical indication for the purchase of this device. Therefore, this request is recommended for non-certification.