

Case Number:	CM14-0161088		
Date Assigned:	10/06/2014	Date of Injury:	02/20/2013
Decision Date:	03/06/2015	UR Denial Date:	09/19/2014
Priority:	Standard	Application Received:	10/01/2014

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. 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: Orthopedic Surgery, Sports 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 57-year-old male who reported an injury on 02/20/2013. The mechanism of injury was due to a fall. Diagnoses include status post left shoulder arthroscopic decompression with history of heavy, massive rotator cuff tear. His past treatments include surgery and medication. His pertinent surgical history included a left shoulder arthroscopy on 10/31/2013. On 08/19/2014, the injured worker complained of left shoulder pain with a constant stabbing sensation rated a 3/10 with an increase of 7/10. The physical examination of the cervical spine revealed flexion of 45 degrees, extension of 30 degrees, a tilt of 30 degrees bilaterally, rotation at 70 degrees on the right and 60 degrees on the left. The cervical spine was absent of tenderness. The examination of the shoulders revealed active range of motion, decreased on the right with active abduction at 0 to 180 degrees, or flexion at 0 to 180 degrees, extension at 40 degrees, and adduction at 0 to 40 degrees. Passive glenohumeral joint abduction with scapula fixed at 90 degrees, external rotation and maximal abduction at 90 degrees and internal rotation and maximum adduction at 15 degrees. Active shoulder range of motion on the left was noted with abduction at 0 to 90 degrees, forward flexion at 0 to 110 degrees, extension at 50 degrees, adduction at 0 to 15 degrees, passive glenohumeral joint abduction with scapula 60 to 90 degrees, external rotation and maximum abduction at 70 degrees, and internal rotation and maximum adduction at 25 degrees. The injured worker was also indicated to have a positive Neer's and Hawkins sign on the left and negative on the right. The injured worker had tenderness to palpation on the left with decreased muscle strength on the left also. Relevant medications included hypertension medication, omeprazole, and over the counter Tylenol. The

treatment plan included preoperative medical clearance, a sling, cold therapy unit, postoperative physical therapy, and postoperative medication. A rationale for the request was not provided. A Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit and pad for purchase: 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 (ODG) Knee & Leg, Continuous-flow cryotherapy.

Decision rationale: The request for cold therapy unit and pad for purchase is not medically necessary. According to Official Disability Guidelines, continuous flow cryotherapy units are recommended as an option after surgery for up to 7 days to include home use. The units have been proven to decrease pain, inflammation, swelling, narcotic usage, and acute injury such as muscle strains and contusions postoperatively. The injured worker was indicated to be considering a reverse total shoulder replacement. The injured worker would meet guideline recommendations for the unit if deemed to be proceeding with the surgical procedure. However, the request as submitted failed to specify the duration of use for cold therapy unit and pad for purchase. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.