

Case Number:	CM14-0216724		
Date Assigned:	01/06/2015	Date of Injury:	06/06/2011
Decision Date:	03/25/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	12/26/2014

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 60-year-old male who reported an injury on 06/06/2011 due to cumulative trauma. His diagnoses were cervical and brachial pain, lumbar facet syndrome, lumbar sprain/strain, right shoulder impingement syndrome, right shoulder internal derangement, status post surgery of the right knee, and total knee replacement. The clinical note dated 10/03/2014 revealed the patient complained of cervical pain that radiated from the shoulder. He also had complaints of pain to the lumbar spine, right shoulder, and right knee. Examination of the right shoulder noted painful range of motion. The range of motion values were 90/180 degrees of abduction, 30/40 degrees of adduction, 35/50 degrees of extension, 45/90 degrees of external rotation, 90/180 degrees of flexion, and 45/80 degrees of internal rotation. There was tenderness noted to palpation to the acromioclavicular joint, anterior shoulder, lateral shoulder, and posterior shoulder. There was a positive supraspinatus test. There was a positive Neer's. Speed's test caused pain. There was a positive right sided Codman's. The provider recommended an immobilizer, and a cold therapy unit with pads and wrap for the right shoulder. The provider's rationale was not provided. The Request for Authorization Form was not included in the medical documents for review.

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 pad/wrap right shoulder for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

Decision rationale: The request for cold therapy unit pad/wrap right shoulder for purchase is not medically necessary. The California MTUS/ACOEM Guidelines state that at home applications of heat or cold packs help aid in exercises. There is no evidence to support that a cold therapy unit would be more effective than at home applications of cold packs for the injured worker. Additionally, the cold therapy unit was for postsurgical treatment, and the provider noted the need to purchase versus renting. As the requested cold therapy unit would not be indicated, a pad/wrap for the right shoulder would not be indicated. As such, medical necessity has not been established.

Associated surgical service: right shoulder immobilizer for purchase: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

Decision rationale: The request for right shoulder immobilizer for purchase is medically necessary. The California MTUS Guidelines state that prolonged use of slings is only needed for symptom control. A 3 week use or less of a sling after an initial shoulder dislocation and reduction is indicated. This review presumes that a surgery is planned and will proceed. As such, medical necessity has been established.

Associated surgical service: cold therapy unit right shoulder for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

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pad/wrap for the right shoulder would not be indicated. As such, medical necessity has not been established.