

Case Number:	CM15-0127733		
Date Assigned:	07/14/2015	Date of Injury:	07/05/2008
Decision Date:	08/10/2015	UR Denial Date:	06/13/2015
Priority:	Standard	Application Received:	07/01/2015

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: Emergency 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 65 year old male, who sustained an industrial injury on 7/5/2008. The mechanism of injury was pushing a sack of rocks. The injured worker was diagnosed as having right shoulder rotator cuff strain, right shoulder adhesive capsulitis and rotator cuff tear. Right shoulder magnetic resonance imaging showed a full thickness rotator cuff tear with tendinopathy and left shoulder x ray showed left total arthroplasty in position. Treatment to date has included multiple shoulder surgeries, therapy and medication management. In a progress note dated 2/11/2015, the injured worker complains of bilateral shoulder pain. Physical examination showed tenderness to the bilateral shoulders and left shoulder restricted and painful range of motion. The treating physician is requesting post-operative ice machine to the right shoulder-7 day rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative ice machine to the right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous Flow Cryotherapy.

Decision rationale: The requested Post-operative ice machine to the right shoulder, is not medically necessary. CA MTUS is silent on this issue and Official Disability Guidelines, Shoulder, Continuous Flow Cryotherapy, recommends up to 7 days post-op cold therapy. In a post-operative setting, cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The injured worker has bilateral shoulder pain. Physical examination showed tenderness to the bilateral shoulders and left shoulder restricted and painful range of motion. The treating physician did not document the medical necessity for continued use of cold therapy beyond the guideline recommended seven days usage. The criteria noted above not having been met, Post-operative ice machine to the right shoulder is not medically necessary.