

Case Number:	CM15-0171784		
Date Assigned:	09/14/2015	Date of Injury:	02/12/2013
Decision Date:	10/13/2015	UR Denial Date:	08/25/2015
Priority:	Standard	Application Received:	08/31/2015

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, Oregon, Washington
 Certification(s)/Specialty: Orthopedic Surgery

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 (IW) is a 57 year old female who sustained an industrial injury on 02-12-2013. She reported a left knee and left shoulder injury. The injured worker was diagnosed as having left rotator cuff tear. Treatment has included trigger point injections in the left shoulder, and a MRI arthrogram of the left shoulder (05-12-2015) that showed a tear of the superior glenoid labrum and a full thickness tear of the posterior distal supraspinatus tendon with no tendon retraction. A left shoulder surgery was done (04/30/2013) for a SLAP (superior labral tear from anterior to posterior) tears x2 and a bursal repair. The worker has also received cortisone injections, physical therapy, and medications. In the exam dated 08/07/2015, the injured worker complains of left shoulder pain. She has moderate tenderness to palpation at the left anterior shoulder, muscle strength 5 of 5 bilaterally with increased pain with abduction on the left side. The impression is for left shoulder pain status post arthroscopic surgery, right shoulder pain status post arthroscopic surgery, left knee pain status post arthroscopic surgery, chronic pain syndrome, and myofascial pain. The plan was for continuation of pain medications and shoulder injections as needed. When the worker was seen 08/13, 2015 for a possible left shoulder cortisone injection, her pain was present in the lateral deltoid area and was aggravated by reaching overhead. Objectively, the left shoulder range of motion was 180/90/80 with a positive impingement sign, a prominent biceps, and pain and weakness with abduction strength testing. The diagnostic impression was for a left rotator cuff tear, and the treatment plan included surgical treatment. A request for authorization was submitted 08/18/2015 for: 1. Left Shoulder acromioplasty (revision), labral debridement, and rotator cuff repair 2. Associated

Surgical Service: Preoperative EKG3. Associated Surgical Service: Preoperative Complete Blood Count4. Associated Surgical Service: Preoperative Complete Metabolic Panel5. Associated Surgical Service: Post-operative physical therapy sessions, 126. Associated Surgical Service: Cold Therapy Unit/Immobilizer (indefinite use)7. Norco 7.5/325mg quantity 1008. Associated Surgical Service: Cold Therapy/Immobilizer for 7 daysA utilization review decision (08-25-2015) approved the left shoulder acromioplasty (revision), Labral Debridement, and Rotator Cuff repair, approved the Pre-op EKG, CBC, CMP, and the post op physical therapy sessions (12). Also approved was Norco 7.5/325mg quantity 100. The Cold Therapy Unit/Immobilizer was given modified approval of 7 days, and Cold Therapy Unit/Immobilizer (indefinite use) was denied.

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/Immobilizer (indefinite use): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cold compression therapy.

Decision rationale: CA MTUS/ACOEM is silent on the issue of cold compression therapy. According to the ODG, Cold compression therapy, it is not recommended in the shoulder as there are no published studies. It may be an option for other body parts such as the knee although randomized controlled trials have yet to demonstrate efficacy. As the guidelines do not recommend the requested DME, the determination is for non-certification. The request is not medically necessary.