

Case Number:	CM15-0073066		
Date Assigned:	04/23/2015	Date of Injury:	09/11/2014
Decision Date:	05/21/2015	UR Denial Date:	03/31/2015
Priority:	Standard	Application Received:	04/16/2015

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: Arizona, California

Certification(s)/Specialty: Family Practice

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 29 year old male, who sustained an industrial injury on 09/11/2014. He has reported injury to the left shoulder. The diagnoses have included left shoulder labral tear; and left shoulder tendinitis and impingement syndrome. Treatment to date has included medications, diagnostics, injection, and physical therapy. Medications have included Voltaren, Ultram, and Protonix. A progress note from the treating physician, dated 03/09/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of left shoulder pain; pain is rated 6/10 on the visual analog scale at rest, and 9/10 with activity; and also has numbness, tingling, weakness, and anxiety. Objective findings have included left shoulder tenderness to palpation over the greater tuberosity in the area of the supraspinatus tendon, and at the anterior joint capsule; and positive Hawkin's impingement maneuver. The treatment plan has included surgical intervention to the left shoulder and the request for post-operative cold compression unit 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 Cold Compression Unit 7 Day Rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211, Chronic Pain Treatment Guidelines Page(s): 92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cold compression therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-shoulder guidelines and pg 10.

Decision rationale: According to the guidelines: Postoperative use of cryotherapy generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries/Compressions however is not recommended due to low risk of DVT for shoulder surgeries. Since the request is for compression and cryo (cold) therapy, the request for post-op 7-day rental of the unit is not medically necessary.