

Case Number:	CM15-0076315		
Date Assigned:	04/27/2015	Date of Injury:	12/08/2010
Decision Date:	06/12/2015	UR Denial Date:	03/31/2015
Priority:	Standard	Application Received:	04/21/2015

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: New York

Certification(s)/Specialty: Neurological 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 is a 47 year old female who sustained an industrial injury on 12/08/2010. Diagnoses include disorders of bursa and tendons in the shoulder region, displacement of cervical intervertebral disc without myelopathy, and brachial neuritis or radiculitis. Treatment to date has included diagnostic studies, medications, steroid injections, acupuncture, physical therapy, and exercises. A physician progress note dated 03/16/2015 documents the injured worker has increased pain in both shoulders and the neck along with low back pain and pain into her legs. Her shoulder pain is greater in the left than the right. The pain in her arms and hands is associated with tingling, numbness and a little weakness in the right shoulder/arm. She rates her pain as 9 on a scale of 0-10. Cervical spine range of motion is full. Left shoulder range of motion is reduced in abduction and forward flexion. There is tenderness to palpation over the anterior aspect of the left shoulder. There is positive Hawkins's and positive Drop arm test. She has a positive crossed arm adduction test. The treatment plan is for surgery. Treatment requested is for post-operative Cold Care Unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative Cold Care Unit: 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), Shoulder Chapter.

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

Decision rationale: ODG guidelines do recommend continuous flow cryotherapy in the post operative setting for shoulder surgery. The guidelines state the use up to seven days is recommended. Cold compression therapy is not recommended. The requested treatment: Post-operative Cold Care Unit does not designate the time limitation and is NOT medically necessary and appropriate.