

Case Number:	CM15-0076412		
Date Assigned:	04/28/2015	Date of Injury:	01/30/2014
Decision Date:	05/26/2015	UR Denial Date:	04/10/2015
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: California, Indiana, Oregon
 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 is a 52 year old male, who sustained an industrial injury on 01/03/2014. He has reported subsequent shoulder pain and was diagnosed with complete rupture of rotator cuff, disorders of bursae and tendons in the shoulder region and osteoarthritis of the shoulder. Treatment to date has included oral pain medication and physical therapy. In a progress note dated 03/26/2014, the injured worker complained of left shoulder pain with associated weakness and stiffness. Objective findings were notable for tenderness to palpation over the AC joint, mild tenderness to palpation over the biceps tendon and bicipital groove, weakness with resisted abduction and external rotation and positive Neer's, Hawkin's and O'brien's tests. The physician noted that left shoulder surgery was recommended and a request for authorization of a cold therapy rental unit as an associated surgical service was submitted.

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 (rental): Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines, 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.

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. The request for authorization dated 4/3/15, states the request is for one week rental for post operative care. This is in keeping with guidelines and is therefore medically necessary.