

Case Number:	CM13-0011943		
Date Assigned:	03/19/2014	Date of Injury:	09/09/2010
Decision Date:	04/30/2014	UR Denial Date:	08/09/2013
Priority:	Standard	Application Received:	08/15/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Occupational Medicine, and is licensed to practice in California. 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 Physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 61-year-old male with a 9/9/10 date of injury. At the time of request for authorization (8/2/13) for polar care rental (per day) qty: 21.00, 1 pain catheter, and ReJuveness silicone sheeting, there is documentation of subjective (right shoulder pain) and objective (decreased and painful range of motion and tenderness along the head of the biceps tendon and rotator cuff) findings, current diagnosis (impingement syndrome of right shoulder), and treatment to date (physical therapy and medications). Medical reports identifying a previous certification for right shoulder arthroscopy, rotator cuff repair, modified Mumford procedure, and evaluation of labrum and biceps. Regarding polar care rental (per day) qty: 21.00, the request exceeds guidelines

IMR ISSUES, DECISIONS AND RATIONALES

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

POLAR CARE RENTAL (PER DAY) QTY: 21.00: 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) - Treatment in Workers' Comp (TWC), Integrated Treatment/Disability Duration 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), Section Shoulder, Polar Care (cold therapy unit).

Decision rationale: The MTUS guidelines do not address this issue. The ODG guidelines identify that continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use. Within the medical information available for review, there is documentation of a diagnosis of impingement syndrome of right shoulder. In addition, there is documentation of a previous certification for right shoulder arthroscopy, rotator cuff repair, modified Mumford procedure, and evaluation of labrum and biceps. However, the request exceeds guidelines (for up to 7 days, including home use). Therefore, based on guidelines and a review of the evidence, the request for polar care rental (per day) qty: 21.00 is not medically necessary.

1 PAIN CATHETER: 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) - Treatment in Workers' Comp (TWC), Integrated Treatment/Disability Duration Guidelines, Shoulder Chapter, Post-Operative Pain Pump.

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

Decision rationale: The MTUS guidelines do not address this issue. The ODG guidelines identify that post-operative pain pump is not recommended and that there is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measure. Therefore, based on guidelines and a review of the evidence, the request for one (1) pain catheter is not medically necessary.

REJUVENESS SILICONE SHEETING: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <https://www.rejuveness.com>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation AETNA

Decision rationale: The MTUS and ODG guidelines do not address the issue. The AETNA Medical Treatment Guidelines identify that silicone products (e.g., sheeting, gels, rigid shells) are experimental and investigational for the treatment of hypertrophic scars or keloids because there is inadequate evidence from prospective randomized clinical trials in the peer-reviewed published medical literature of the effectiveness of silicone products in alleviating symptoms of

hypertrophic scars and keloids. Therefore, based on guidelines and a review of the evidence, the request for ReJuveness silicone sheeting is not medically necessary.