

Case Number:	CM13-0025912		
Date Assigned:	11/20/2013	Date of Injury:	07/19/2011
Decision Date:	02/11/2014	UR Denial Date:	08/16/2013
Priority:	Standard	Application Received:	09/18/2013

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 Orthopedic Surgery 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:

The claimant is a 51-year-old female who was recommended to undergo revision shoulder surgery following a vocationally related injury of 07/19/11. The request was to determine the medical necessity of a series of requested treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

ThermoCool Hot and Cold contrast therapy with compression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Section, continuous flow cryotherapy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Cold therapy units/CPM.

Decision rationale: The ThermoCool hot and cold therapy compression combo care unit for 30 days would not be considered reasonably medically necessary. The MTUS ACOEM Guidelines are silent in this regard, but Official Disability Guidelines states that cryotherapy units can be of benefit for the first seven days, but would not be recommended beyond that period of time. As such, a request in this particular case would not be considered reasonably medically necessary. Although, an alternative would not be considered reasonably medically necessary in this setting.

MTUS ACOEM Guidelines do not address the issues of CPM postop following shoulder surgery. Official Disability Guidelines states that there are no well controlled peer reviewed studies that would support its use. As such, in this particular case, the request would not be considered reasonably medically necessary.

Ultra Sling with Abduction pillow: 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) Chapter Shoulder: Postoperative abduction pillow and sling

Decision rationale: The MTUS Guidelines do not address the issues of ultra sling, but the Official Disability Guidelines would consider this an option for patients who are treated for massive rotator cuff pathology. The records in this particular case fail to demonstrate any evidence that this patient has massive rotator cuff pathology. In fact, the imaging studies appear to describe partial thickness rotator cuff pathology and as such there would be no indication for use of an ultra sling in this particular setting. I think that addresses the request in this particular case.

Pain Pump: 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, Postoperative 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), Shoulder Chapter, Postoperative Pain Pump.

Decision rationale: The Physician Reviewer's decision rationale: MTUS Guidelines do not address the issues of a pain pump postoperatively. Official Disability Guidelines, however, does not recommend this particular device. They cite multiple, well controlled studies that fail to document its efficacy in this setting.