MAXIMUS Federal Services

Case Number:	CM13-0031845		
Date Assigned:	12/04/2013	Date of Injury:	01/09/2013
Decision Date:	01/29/2014	UR Denial Date:	09/10/2013
Priority:	Standard	Application Received:	10/04/2013

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 Physical Medicine & Rehabilitation 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:

This 36 year-old female sustained an injury after being struck by a falling object in the right shoulder on 1/9/13 while employed by [redacted]. Request under consideration include Cold Therapy System purchase with pads/wrap, Abductor pillow, Physical therapy 2x/wk. x 9 weeks, Post-op brace, and CPM rental x 6 weeks for the Right shoulder. Diagnoses include Disorders of bursae and tendons in shoulder region, unspecified; other affections of shoulder region not elsewhere classified. MRI report dated 2/7/13 noted hypertrophic changes at AC joint, edematous changes at subacromial/subdeltoid bursa, tendinosis of distal infraspinatus tendon and possible "rim-rent" tear. Medical report dated 8/15/13 from [redacted] noted there is a complete tear of the supraspinatus tendon where it inserts into the greater tuberosity; she has failed conservative efforts to manager her shoulder injury; and she was subsequently approved for surgery. The rotator cuff repair and decompression is scheduled for 9/20/13. Treatment has included cortisone steroid injections, formal physiotherapy (at 14 PT visits), and medications, Requests were non-certified by [redacted], ortho on 9/10/13, citing guidelines and medical indication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy system, purchase: 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, Continuous-flow cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers' Comp, 9th edition, Knee Chapter, Continuous-Flow Cryotherapy, page 292:

Decision rationale: The Physician Reviewer's decision rationale: This female sustained an injury after being struck by a falling object in the right shoulder on 1/9/13 while employed by [redacted]. The patient was scheduled for the rotator cuff repair and decompression for 9/20/13 now with request for cold therapy system purchase with pads and wraps. Regarding Cold therapy guidelines state it is "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use". The request for authorization does not provide supporting documentation for purchase beyond the guidelines criteria. There is no documentation that establishes medical necessity or that what is requested is medically reasonable outside recommendations of the guidelines. The request for a Cold therapy System purchase with Cold Therapy pad & wrap, right shoulder do not meet the requirements for medical necessity. MTUS Guidelines is silent on specific use of cold compression therapy with pad and wrap, but does recommend standard cold pack for post exercise. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post knee surgery; however, limits the use for 7-day post-operative period as efficacy has not been proven after. The Cold Therapy system purchase is not medically necessary and appropriate; therefore all accessories including the Cold Therapy Pad & Wrap are not medically necessary and appropriate.

Cold therapy pad & wrap, right shoulder, post-op: 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, Continuous-flow cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers' Comp, 9th edition, Knee Chapter, Continuous-Flow Cryotherapy, page 292

Decision rationale: The Physician Reviewer's decision rationale: This female sustained an injury after being struck by a falling object in the right shoulder on 1/9/13 while employed by [redacted]. The patient was scheduled for the rotator cuff repair and decompression for 9/20/13 now with request for cold therapy system purchase with pads and wraps. Regarding Cold therapy guidelines state it is "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use". The request for authorization does not provide supporting documentation for purchase beyond the guidelines criteria. There is no documentation that establishes medical necessity or that what is requested is medically reasonable outside recommendations of the guidelines. The request for a Cold therapy System purchase with Cold Therapy pad & wrap, right shoulder do not meet the

requirements for medical necessity. MTUS Guidelines is silent on specific use of cold compression therapy with pad and wrap, but does recommend standard cold pack for post exercise. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post knee surgery; however, limits the use for 7-day post-operative period as efficacy has not been proven after. The Cold Therapy system purchase is not medically necessary and appropriate; therefore all accessories including the Cold Therapy Pad & Wrap are not medically necessary and appropriate.

Abduction pillow, right shoulder: 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, Continuous-flow cryotherapy

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 Abduction Pillow Sling/Brace

Decision rationale: The Physician Reviewer's decision rationale: This female sustained an injury after being struck by a falling object in the right shoulder on 1/9/13 while employed by [redacted]. The patient was scheduled for the rotator cuff repair and decompression for 9/20/13 now with request for Abductor pillow. Per UR report from orthopedist on 9/10/13, the patient is scheduled to undergo subacromial decompression with a rotator cuff repair of the right shoulder. MTUS/ACOEM guidelines do not specifically address this; however, the Official Disability Guidelines state that postoperative abduction pillow slings and braces are recommended as an option following an open repair of large or massive rotator cuff tears. Abduction pillows for large or massive tears may decrease tendon contact to the prepared sulcus but are not recommended by guideline recommendations. Submitted reports have not demonstrated the medical necessity outside the recommendations of Guidelines criteria. The Abduction pillow and Post-op Brace, right shoulder is not medically necessary and appropriate

Physical therapy twice weekly x 9 weeks, right shoulder: 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, Continuous-flow cryotherapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Post-operative Physical Therapy for Shoulder Page(s): 26-27.

Decision rationale: The Physician Reviewer's decision rationale: This female sustained an injury after being struck by a falling object in the right shoulder on 1/9/13 while employed by [redacted]. The patient was scheduled for the rotator cuff repair and decompression for 9/20/13 now with request for PT twice weekly x 9 weeks. Request was partially-certified by UR on 9/10/13 for initial half sessions of 12 visits with further consideration pending outcome. Submitted reports have not adequately demonstrated any functional outcome to support for the

18 post-operative formal PT sessions outside the recommendations of the Guidelines for a non-complicated arthroscopic decompression rotator cuff repair. The Physical Therapy twice weekly x 9 weeks, right shoulder is not medically necessary and appropriate.

Post-op brace, right shoulder: 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, Continuous-flow cryotherapy

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 Abduction Pillow Sling/Brace

Decision rationale: The Physician Reviewer's decision rationale: This female sustained an injury after being struck by a falling object in the right shoulder on 1/9/13 while employed by [redacted]. The patient was scheduled for the rotator cuff repair and decompression for 9/20/13 now with request for Abductor pillow. Per UR report from orthopedist on 9/10/13, the patient is scheduled to undergo subacromial decompression with a rotator cuff repair of the right shoulder. MTUS/ACOEM guidelines do not specifically address this; however, the Official Disability Guidelines state that postoperative abduction pillow slings and braces are recommended as an option following an open repair of large or massive rotator cuff tears. Abduction pillows for large or massive tears may decrease tendon contact to the prepared sulcus but are not recommended by guideline recommendations. Submitted reports have not demonstrated the medical necessity outside the recommendations of Guidelines criteria. The Abduction pillow and Post-op Brace, right shoulder is not medically necessary and appropriate.

CPM machine rental x 6 weeks, right shoulder: 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, Continuous-flow cryotherapy

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, pgs. 909-910

Decision rationale: This female sustained an injury after being struck by a falling object in the right shoulder on 1/9/13 while employed by [redacted]. The patient was scheduled for the rotator cuff repair and decompression for 9/20/13 now with request for CPM rental x 6 weeks. Per UR report from orthopedist on 9/10/13, the patient is scheduled to undergo subacromial decompression with a rotator cuff repair of the right shoulder. MTUS/ACOEM guidelines do not specifically address this; however, the Official Disability Guidelines state Continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment and postoperative use generally may be up to 7 days, including home use. Submitted reports have

not demonstrated the medical necessity outside the recommendations of Guidelines criteria. The CPM machine rental x 6 weeks, right shoulder is not medically necessary and appropriate.