

Case Number:	CM13-0043864		
Date Assigned:	12/27/2013	Date of Injury:	12/22/2011
Decision Date:	07/31/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/31/2013

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. The expert 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 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/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 injured worker is a 39-year-old female who reported an injury on 12/22/2011 with the mechanism of injury not cited within the documentation provided. In the clinical notes dated 09/05/2013, the injured worker complained of pain in the right shoulder and low back. It was noted that the injured worker stated that the pain in her lumbar spine was not too bad but still felt stiff and her right shoulder pain continued. Prior treatments included physical therapy, injections, and prescribed pain medications. In the physical examination of the right shoulder, it revealed restricted and painful range of motion with a positive impingement test. There was also tenderness over the greater tuberosity of the humerus. The diagnoses included lumbar spine sprain/strain with herniated nucleus pulposus, L4-5 and L5-S1 with right lower extremity radiculopathy; and right shoulder sprain/strain with subacromial impingement without improvement with subacromial injection. The treatment plan included a Request for Authorization for the right shoulder scope arthroscopic surgery with subacromial decompression and lumbar epidural steroid injection #2 at L4-5 and L5-S1. Risks and benefits were discussed with the injured worker pertaining to the procedures. There was also a request for postoperative hot/cold contrast unit and abduction sling. The Request for Authorization for hot/cold contrast unit rental for 90 days and Pro-Sling abduction sling was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOT/COLD CONTRAST UNIT RENTAL FOR 90 DAYS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Worker's Comp 18th Edition, Crotherapy.

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

Decision rationale: The request for hot/cold contrast unit rental for 90 days is non-certified. The Official Disability Guidelines (ODG) state that continuous flow cryotherapy is recommended as an option after surgery and generally may be used postoperative up to 7 days to include home use. In the clinical notes provided for review, there is a lack of documentation of the approval or authorization of the requested right shoulder arthroscopic surgery. There is also a lack of documentation of the injured worker's pain level status with or without the use of pain medications. There is also a lack of documentation of the injured worker's progress of physical therapy or participation in a home exercise program. Furthermore, the guidelines do not recommend the use of the hot/cold contrast unit for more than 7 days postoperative. Therefore, the request for hot/cold contrast unit rental for 90 days is non-certified.

PRO-SLING ABDUCTION SLING: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

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

Decision rationale: The request for Pro-Sling abduction sling is non-certified. The Official Disability Guidelines (ODG) state that postoperative abduction pillow/sling is recommended as an option following open repair of large and massive rotator cuff tears. In the clinical notes provided for review, it is annotated that the request is for right arthroscopic scope for the diagnosis of subacromial impingement, however, there is not documentation of the authorization of the surgical intervention. Furthermore, the guidelines state that abduction pillow/slides are for large or massive tears but are not used for arthroscopic repairs. Therefore, the request for Pro-Sling abduction sling is non-certified.