

Case Number:	CM13-0054907		
Date Assigned:	12/30/2013	Date of Injury:	06/15/2013
Decision Date:	04/02/2014	UR Denial Date:	11/05/2013
Priority:	Standard	Application Received:	11/20/2013

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 Family Practice 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 patient is a 67-year-old male who reported an injury on 01/15/2013. The patient was reportedly injured secondary to repetitive steering. The patient is diagnosed with cervical spine sprain/strain with radicular complaints and left shoulder rotator cuff tendonitis/bursitis. The patient was seen by [REDACTED] on 09/19/2013. The patient reported intermittent moderate neck and shoulder pain. Physical examination revealed tenderness to palpation of the left acromioclavicular joint, restricted range of motion, and positive impingement sign. Treatment recommendations included a request for authorization for a left shoulder arthroscopy/rotator cuff repair.

IMR ISSUES, DECISIONS AND RATIONALES

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

One Cryotherapy unit: 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

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, Continuous Flow Cryotherapy

Decision rationale: Official Disability Guidelines state continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. As per the documentation submitted, there has been a request for authorization for a left shoulder arthroscopy/rotator cuff repair. However, it is unknown whether the procedure has been authorized. While the patient may meet criteria for 7 day use of a continuous flow cryotherapy unit following surgery, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

One shoulder brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205.

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, Post-operative Abduction Pillow Sling

Decision rationale: Official Disability Guidelines state postoperative abduction pillow sling is recommended as an option following open repair of large and massive rotator cuff tears. As per the documentation submitted, there was a request for authorization for a left shoulder arthroscopy/rotator cuff repair. There is no indication that the patient is scheduled to undergo an open repair of a large and massive rotator cuff tear. Therefore, the patient does not meet criteria for the requested durable medical equipment. As such, the request is non-certified.

One TENS unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home-based trial may be considered as a noninvasive conservative option. Postoperative use of a TENS unit is recommended as a treatment option in the first 30 days post surgery. As per the documentation submitted, there is a request for authorization of a left shoulder arthroscopy/rotator cuff repair. However, it is unknown whether the patient's surgical procedure has been authorized. Additionally, California MTUS Guidelines only recommend TENS therapy in the first 30 days post surgery. Based on the clinical information received, the request is non-certified.