MAXIMUS Federal Services

Case Number:	CM13-0056182		
Date Assigned:	12/30/2013	Date of Injury:	05/25/2012
Decision Date:	06/04/2014	UR Denial Date:	10/14/2013
Priority:	Standard	Application Received:	11/22/2013

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 Texas. 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 45 year old male who reported an injury to his neck and both shoulders. The clinical note dated 08/31/12 indicates the patient complaining of radiculopathy involving the left upper extremity. The patient was able to demonstrate 160 degrees of flexion ant the left shoulder along with 160 degrees of abduction, 80 degrees of external rotation, and 60 degrees of internal rotation. The note indicates the patient being directed to initiate therapy at that time. The therapy note dated 09/21/12 indicates the patient having completed 10 physical therapy sessions to date. The operative report dated 01/07/13 indicates the patient undergoing an arthroscopic debridement of the supraspinatus as well as decompression and debridement of the glenoid labrum. The therapy note dated 03/06/13 indicates the patient having completed 9 additional physical therapy sessions to date. The MRI of the left shoulder dated 06/11/13 revealed mild edema at the AC joint. An irregularity was also identified at the acromial aspect of the joint. Findings consistent with degenerative changes were also identified. The clinical note dated 07/03/13 indicates the patient rating his left shoulder pain as 5-6/10. The patient continued with range of motion limitations throughout the left shoulder. The clinical note dated 07/29/13 indicates the patient continuing with intermittent moderate pain in the cervical spine with radiating pain to both upper extremities. The patient also reported numbness and tingling. The patient was provided with an intraarticular injection at the left subacromial space. The clinical note dated 07/31/13 indicates the patient able to demonstrate 180 degrees of left shoulder flexion, 40 degrees of extension, 175 degrees of abduction, and 40 degrees of adduction. The patient has no specific complaints of pain at that time. The clinical note dated 09/23/13 indicates the patient presenting with well-healed arthroscopic portals. No erythema or drainage was identified. There is an indication that the patient underwent an arthroscopic procedure at the left shoulder on 07/07/13. The patient continued with complaints of persistent pain primarily as a

result of activities. There is an indication that the patient is demonstrating postoperative instability at the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pro-sling with abduction pillow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563. Decision based on Non-MTUS Citation ODG Shoulder (updated 6/12/13) Postoperative abduction pillow sling.

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.

Decision rationale: The request for a pro-sling with abduction pillow is not medically necessary. The documentation indicates the patient complaining of a long history of left shoulder pain with associated range of motion deficits. There is an indication the patient had undergone an operative procedure at the left shoulder; however, no operative notes were submitted confirming this procedure. There is no indication in the clinical notes on that date confirming an operative procedure. Therefore, the request for an abduction pillow is indicated in the postoperative setting; however, given that no information was submitted confirming the operative procedure at the left shoulder, this request is not indicated as medically necessary.

Motorized Hot/Cold Unit for 30 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 555-556. Decision based on Non-MTUS Citation ODG Shoulder (updated 6/12/13) 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, Continuous-flow cryotherapy.

Decision rationale: The request for a motorized hot and cold unit for 30 days is not medically necessary. The documentation indicates the patient complaining of a long history of left shoulder pain with associated range of motion deficits. There is an indication the patient had undergone an operative procedure at the left shoulder; however, no operative notes were submitted confirming this procedure. There is no indication in the clinical notes on that date confirming an operative procedure; therefore, the request for a hot and cold motorized unit is indicated in the postoperative setting; however, given that no information was submitted confirming the operative procedure at the left shoulder, this request is not indicated as medically necessary.