

Case Number:	CM13-0062175		
Date Assigned:	12/30/2013	Date of Injury:	09/20/2011
Decision Date:	05/07/2014	UR Denial Date:	11/21/2013
Priority:	Standard	Application Received:	12/06/2013

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:

This 55-year-old male cook sustained a right shoulder injury on 9/20/11 lifting 55-pound boxes of potatoes. The patient underwent a right shoulder capsulolabral reconstruction, synovectomy, bursectomy, and subacromial decompression on 10/25/12. The 6/20/13 right shoulder MRI arthrogram impression documented a chronic appearing anteroinferior labral tear just distal to the suture anchor, glenohumeral capsulitis and synovitis, moderate rotator cuff tendinosis and Type II laterally downsloping acromion with moderate acromioclavicular osteoarthritis. The 11/11/13 treating physician report cited right shoulder pain, worse with overhead reaching and dressing. Objective findings documented functional right shoulder range of motion, positive impingement sign, and tenderness to palpation over the anterior shoulder. The diagnosis was recurrent right shoulder injury, possible right biceps tendinitis, right shoulder impingement syndrome, probable persistent SLAP lesion, and cervicobrachial syndrome with cervical disc disease. The patient opted for surgical treatment over conservative options. Authorization for right shoulder arthroscopy, subacromial decompression, possible rotator cuff repair, possible SLAP repair, possible open biceps tenodesis and excision distal clavicle was requested and non-certified in utilization review. Post-operative physical therapy was non-certified based on non-certification of the right shoulder surgery. Under consideration is a request for stable abduction sling and continuous flare cryotherapy unit with cryotherapy bladder.

IMR ISSUES, DECISIONS AND RATIONALES

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

STABLE ABDUCTION SLING: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 561-563.

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 Abduction Pillow Sling

Decision rationale: Under consideration is a request for stable abduction sling. The California MTUS guidelines do not provide recommendations for post-operative shoulder slings in chronic cases. The Official Disability Guidelines recommend abduction slings as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. There is no indication that this patient has a massive rotator cuff tear or will undergo an open repair. The medical necessity of this request is not established as the proposed surgery has not been certified. Therefore, this request for a stable abduction sling is not medically necessary.

CONTINUOUS-FLOW CRYOTHERAPY UNIT, CRYOTHERAPY BLADDER: Upheld

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

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

Decision rationale: Under consideration is a request for continuous flow cryotherapy unit with cryotherapy bladder. The California MTUS guidelines do not provide recommendations for continuous flow cryotherapy. The Official Disability Guidelines recommend these units as an option after surgery, but not for non-surgical treatment. The medical necessity of this request is not established as the proposed surgery has not been certified. Guidelines do not support use for non-surgical treatment. Therefore, this request for continuous flow cryotherapy unit with cryotherapy bladder is not medically necessary.