

Case Number:	CM13-0069423		
Date Assigned:	01/03/2014	Date of Injury:	05/01/2013
Decision Date:	04/21/2014	UR Denial Date:	11/19/2013
Priority:	Standard	Application Received:	12/23/2013

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 Occupational Medicine, 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 patient is a 37 year old male who was injured on 05/01/2013 while lifting 250 lbs of tuna fish with a co-worker. Prior treatment history has included right dorsal forearm injection, two injections in the right shoulder, and physical therapy. Diagnostic studies reviewed include MR Arthrogram of the right shoulder dated 09/24/2013 revealing tendinopathy at the junction of the supraspinatus and infraspinatus tendons with near full-thickness bursal surface tear. No full thickness rotator cuff tear. SLAP tear without paralabral cyst formation. UR Determination note dated 10/22/2013: 1. Right shoulder arthroscopy between 10/14/2013 and 12/01/2013 be certified. 2. Right subacromial decompression between 10/14/2013 and 12/01/2013 be certified. 3. Right Mumford and rotator cuff repair between 10/14/2013 and 12/01/2013 be certified. 4. 12 Postoperative physical therapy sessions right shoulder between 10/14/2013 and 12/01/2013 be certified. PR-2 dated 11/04/2013 documented the patient with complaints of persistent right shoulder pain. Objective findings on exam included weakness of right shoulder. Decreased range of motion with spasm. Treatment Plan: Proceed with right shoulder arthroscopy, subacromial decompression, Mumford and repair rotator cuff.

IMR ISSUES, DECISIONS AND RATIONALES

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

THE RENTAL OF A PNEUMATIC DEVICE: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic), Compression garments.

Decision rationale: CA MTUS does not discuss the issue in dispute and hence the ODG have been consulted. In this case, this patient has been previously approved for right shoulder arthroscopy on October 22, 2013. As per ODG, compression garments are recommended for complications following lower-extremity orthopedic surgery such as deep venous thrombosis and pulmonary embolism events; however, there is no evidence to support its use for shoulder surgery. The request for the rental of a pneumatic device is not medically necessary or appropriate.

THE PURCHASE OF A COLD THERAPY 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.

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

Decision rationale: CA MTUS guidelines do not discuss the issue in dispute, and hence ODG have been consulted. According to the ODG, "recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated." In this case, this patient has been approved for right shoulder arthroscopy on October 22, 2013. The request for the purchase of a cold therapy unit is not medically necessary or appropriate.

AN ABDUCTION PILLOW: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic), Postoperative abduction pillow sling.

Decision rationale: CA MTUS guidelines do not discuss the issue in dispute and therefore, the ODG have been consulted. According to the ODG, "Recommended as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs." In

this case, this patient is scheduled for an arthroscopic surgery and the guidelines do not support its use. The request for an abduction pillow is not medically necessary or appropriate.

A CONTINUOUS PASSIVE MOTION (CPM) RENTAL: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic), Continuous passive motion (CPM).

Decision rationale: CA MTUS guidelines do not discuss the issue in dispute and hence ODG have been consulted. According to the ODG, CPM is "not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 days per week for five weeks." In this case, this patient has been previously approved for right shoulder arthroscopic rotator cuff repair and guidelines state that CPM is not recommended for shoulder rotator cuff problems. The request for a CPM rental is not medically necessary or appropriate.