

Case Number:	CM14-0104089		
Date Assigned:	07/25/2014	Date of Injury:	09/03/2013
Decision Date:	09/23/2014	UR Denial Date:	06/12/2014
Priority:	Standard	Application Received:	07/07/2014

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 65-year-old male fabricator sustained an industrial injury on 9/3/13. Injury occurred while he was loading airplane parts onto a wooden pallet. One of the parts weighing 150 pounds started to fall off the pallet and he attempted to catch it with sudden sharp right shoulder pain. The 11/19/13 right shoulder MRI impression documented supraspinatus and subscapularis tendinosis with partial tear of the subscapularis tendon. The 4/28/14 treating physician report cited moderately severe right shoulder pain associated with weakness and loss of motion. Pain was worse with straining, lifting, and reaching. He was unable to perform activities of daily living due to pain. Conservative treatment had included activity modification, medications, heat, massage, physical therapy, and acupuncture with no relief. Physical exam documented positive Neer and Hawkin's tests, 4/5 shoulder strength, and shoulder range of motion limited by pain and spasms. Range of motion testing demonstrated flexion 10, extension 40, abduction 100, additional 40, internal rotation 70, and external rotation 60 degrees. A request was submitted for right shoulder arthroscopy, subacromial decompression, and rotator cuff repair along with purchase of a post-operative shoulder sling and cold therapy unit. The 6/12/14 utilization review denied the request for cold therapy unit as there was no indication that motorized units were more beneficial than low-tech cold packs. The shoulder sling was denied as surgery was not currently approved. Records suggested subsequent surgical authorization.

IMR ISSUES, DECISIONS AND RATIONALES

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

SHOULDER SLING - PURCHASE: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Workers' Compensation, online edition, Chapter: Shoulder.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213.

Decision rationale: Under consideration is a request for right shoulder sling. The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. Slings are recommended as an option for patients with acromioclavicular separations or severe sprains. Guideline criteria have been met. The use of a post-operative sling is generally indicated. Therefore, this request is medically necessary.

COLD THERAPY UNIT - PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Workers' Compensation, online edition, Chapter: 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, Continuous flow cryotherapy.

Decision rationale: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. There is limited support for a post-operative cold therapy unit, however this request is for an unknown length of use and is not consistent with guidelines. Therefore, this request is not medically necessary.