

Case Number:	CM14-0016974		
Date Assigned:	03/07/2014	Date of Injury:	08/30/2013
Decision Date:	06/30/2014	UR Denial Date:	01/29/2014
Priority:	Standard	Application Received:	02/10/2014

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, has a subspecialty in Hand 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 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 injured worker is a 56-year-old female who reported an injury on 08/30/2013, due to an unknown mechanism. The clinical note dated 12/11/2013 presented the injured worker with left shoulder pain and stiffness, difficulty sleeping, and anxiety. The injured worker's physical exam of the left shoulder revealed 100 degrees of forward flexion, 90 degrees of subacromial crepitation, weakness with resisted external rotation and resisted abduction. The injured worker was diagnosed with cervical spine sprain/strain with multilevel degenerative disc disease, and foraminal stenosis most profound at C4-C5, left shoulder sprain/strain with adhesive capsulitis in the left supraspinatus rotator cuff tear, and symptoms of anxiety and depression. The request for surgery dated 01/22/2014 for the left shoulder arthroscopy with manipulation with anesthesia, subacromial decompression, and rotator cuff repair has not yet been approved. The request for authorization was not included in this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

CPM MACHINEX 6 WEEKS RENTAL: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 Passive Motion Device

Decision rationale: The request for a continuous passive motion (CPM) machine 6 week rental is non-certified. The Official Disability Guidelines do not recommend CPM after shoulder surgery or for nonsurgical treatment, effectiveness and the harms of various operative and non-operative treatments for rotator cuff tears is limited. CPM for adhesive capsulitis is recommended for treatments for 1 hour once a day for 20 days during a period of 4 weeks. The provider recommended a left shoulder arthroscopy with manipulation under anesthesia, subacromial decompression, and rotator cuff repair; however, it was unclear if the surgical intervention has been approved. Within the medical records, it was unclear when the injured worker is scheduled to undergo surgery. Therefore, it was unclear whether the use of the CPM would be indicated. The request for the CPM 6 week rental would exceed the recommendation of the guidelines. As such, the request is not medically necessary.

ABDUCTION SLING X1: 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 Chapter Immobilization

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: The request for an abduction sling is non-certified. The Official Disability Guidelines recommend an abduction sling 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. The provider recommended a left shoulder arthroscopy with manipulation under anesthesia, subacromial decompression, and rotator cuff repair; however, it was unclear if the surgical intervention has been approved. Within the medical records, it was unclear when the injured worker is scheduled to undergo surgery. Therefore, the request is not medically necessary.

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 (ODG), 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, Cryotherapy

Decision rationale: The request for a cold therapy unit is not certified. The Official Disability Guidelines recommend continuous-flow cryotherapy as an option after surgery for up to 7 days, including home use. The request for one cold unit (continuous flow cryotherapy) exceeds the recommendations of the guidelines. It is unclear if the request was for the purchase or rental of the unit. The medical documents provided do not indicate a medical need for the cryotherapy unit that would fall within the guideline limitations, such as surgery. The provider recommended a left shoulder arthroscopy with manipulation under anesthesia, subacromial decompression, and rotator cuff repair; however, it was unclear if the surgical intervention has been approved. Within the medical records, it was unclear when the injured worker is scheduled to undergo surgery. Therefore, the request is not medically necessary.

POST OP PT 2X6: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: The request for postoperative physical therapy (PT) 2 times per week for 6 weeks is non-certified. The Guidelines recommend post-surgical therapy, up to 24 visits over 14 weeks. The provider recommended a left shoulder arthroscopy with manipulation under anesthesia, subacromial decompression, and rotator cuff repair; however, it was unclear if the surgical intervention has been approved. It did not appear the injured worker has undergone surgical intervention or surgery is scheduled in the near future. Therefore, the request is not medically necessary.