

Case Number:	CM14-0111282		
Date Assigned:	09/16/2014	Date of Injury:	11/30/2011
Decision Date:	11/10/2014	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	07/17/2014

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 Internal 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 injured worker (IW) is a 65-year-old woman who was injured on November 30, 2011. The mechanism of injury was not described in the provided medical records. The IW was diagnosed with osteoarthritis of the shoulder. The IW is status-post right shoulder arthroscopic rotator cuff repair on November 5, 2013. An MRI of the right shoulder on May 19, 2014 reported moderate glenohumeral arthrosis, including full thickening cartilage loss in the anterior-inferior aspect of the glenoid and posteromedial aspect of the humeral head. Moderate sized joint effusion was noted with synovitis and debris. There was a partial-thickness articular sided tear, compromising approximately 50% of the tendon thickness, located approximately 2.1 cm from the footprint. There was degenerative tearing of the superior, anterior-inferior, and poster-inferior labrum. Advanced acromioclavicular joint arthrosis was seen without reactive bone marrow edema. The evaluation on June 5, 2014 noted subjective complaints of persistent right shoulder pain, which prevented the IW from returning to full duty. The physical examination documented normal range of motion. Impingement signs were 2+ positive. Strength was 4/5. Stability was normal. Diagnosis is right shoulder advanced arthritis with healed rotator cuff repair. He is not responding to conservative measures so surgery options were discussed. The IW has opted to proceed with total shoulder arthroscopy. Authorization will be requested. The IW will remain on light duty restrictions. On June 26, 2014 there is a notification of denial stating that the request for right total shoulder arthroplasty was non-certified due to lack of documentation supporting failure of conservative treatment, which negates the need for postoperative cold therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit with pad (7day 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 (ODG) Treatment for Workers' Compensation (TWC)-Shoulder (updated 04/25/14)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Cold Packs, Cold Compression Therapy

Decision rationale: Pursuant to the official disability guidelines, cold therapy unit with pad seven-day rental is not medically necessary. Ordinarily, the cold therapy unit is medically necessary provided the injured worker undergoes the prescribed surgical procedure (shoulder). It is recommended as an option if the injured worker undergoes surgery. Postoperative use may be up to seven days, including home use, and the postoperative setting. Continuous flow cryotherapy units have been noted to decrease pain, inflammation, swelling and narcotic usage. In this case, the guidelines would not support a seven-day rental because the requested shoulder surgery was not certified due to lack of documentation supporting a failure of conservative treatment. This negates the need for postoperative cold therapy. Based on the clinical information in the medical record and the peer review evidence-based guidelines the cold therapy unit with pad is not medically necessary.

Ultrasling with pillow (purchase): 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) Treatment for Workers' Compensation (TWC)-Shoulder (updated 04/25/14)

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Pursuant to the Official Disability Guidelines, the Ultrasling with pillow is not medically necessary. In this case, the medical record was lacking documentation supporting the Ultrasling pillow. The requested shoulder surgery is not certified. The canceled surgery would have negated the need for the Ultrasling pillow. Based on the information in the medical record in the peer-reviewed evidence-based guidelines, the Ultrasling pillow is not medically necessary.