

Case Number:	CM14-0152632		
Date Assigned:	09/23/2014	Date of Injury:	07/04/2010
Decision Date:	10/23/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/18/2014

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:

The claimant is a 43-year-old female who injured her left shoulder on 07/04/10. The medical records provided for review documented on the follow up report of 05/05/14 persistent complaints of pain in the left shoulder despite conservative care including corticosteroid injections and physical therapy. Recommendation at that time was for left shoulder manipulation under anesthesia, arthroscopic debridement, and subacromial decompression. The Utilization Review determination dated 08/15/14 did not authorize the proposed surgery. There are also multiple postoperative requests pertaining to the proposed surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Polar Care Cooling Ice Machine, left shoulder, 4 weeks 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)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205; 555-556. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment in Worker's Comp , 18th Edition, 2013 Updates: shoulder procedure - Continuous-flow cryotherapy

Decision rationale: California MTUS ACOEM Guidelines supported by Official Disability Guidelines would not recommend the use of a Polar Care Cooling Ice Machine for the left shoulder for four weeks. The proposed surgery was not authorized based on the 08/15/14 Utilization Review determination. In addition, while the ACOEM Guidelines recommend the use of cold postoperatively to control pain and swelling, the Official Disability Guidelines typically recommend the use of a cold therapy unit for up to seven days including home use. The request for 28 days or a four week rental of the above device would exceed guideline criteria. In light of the fact the proposed surgery is not recommended as medically necessary, the request for the use of a Polar Care Cooling Machine is also not medically necessary.

TENS Unit for home use, left shoulder, 4 weeks rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS) / Transcutaneous electrotherapy Page(s): 114-.

Decision rationale: California MTUS Chronic Pain Guidelines would not support the use of a TENS device. While TENS devices can be utilized as isolated intervention following surgery, the proposed surgery for the claimant is not recommended as medically necessary based on the 08/15/14 Utilization Review determination. Therefore, the request for use of a TENS unit is also not medically necessary.

CPM Machine, left shoulder, 4 weeks 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 Index, Shoulder, Continuous-flow Cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment in Worker's Comp, 18th Edition, 2013 Updates: Shoulder Chapter; Continuous passive motion (CPM)

Decision rationale: California MTUS and ACOEM Guidelines do not provide criteria relevant to this request. Based on the Official Disability Guidelines, the request for use of a CPM device is not recommended as medically necessary. In light of the fact the proposed surgery is not recommended as medically necessary as determined by the 08/15/14 Utilization Review, the request for use of a CPM machine postoperatively would also not be medically necessary.

Ultrasling, left shoulder, for 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 Index, Shoulder, Immobilization

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - Postoperative abduction pillow sling

Decision rationale: The California MTUS and ACOEM Guidelines do not provide criteria relevant to this request. Based on the Official Disability Guidelines, the request for postoperative use of an Ultrasling is also not recommended as medically necessary. The 08/15/14 Utilization Review determination did not recommend the proposed surgery. Therefore, the request for postoperative use of an Ultrasling is also not recommended as medically necessary.