

Case Number:	CM14-0166899		
Date Assigned:	10/14/2014	Date of Injury:	02/03/2013
Decision Date:	11/28/2014	UR Denial Date:	09/23/2014
Priority:	Standard	Application Received:	10/09/2014

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 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 55 year old female with a date of injury on 2/3/2013. She was employed as a housekeeper at the time of injury. Injury occurred when she was carrying trash to throw in the compactor and felt something tear in her left shoulder. She was diagnosed with a full thickness rotator cuff tear and underwent left shoulder surgery on 5/2/13. The 9/19/14 treating physician report cited constant dull left neck to left shoulder pain, worse in the morning and with activity. Pain occasionally radiated to the left hand with tingling. She was overcompensating with the right arm. Medications, a transcutaneous electrical nerve stimulation (TENS) unit, and heat therapy were reported helpful. Objective exam documented tenderness to palpation over the cervical spine and left paravertebral muscles, inferior scapula, and trapezius and deltoid muscles. Left shoulder pain was reported with global movement. The diagnosis was left shoulder joint pain, tendinitis, and impingement, status post left shoulder surgery. The treatment plan documented ultrasound treatment to the left shoulder and upper back, and continued medications, home exercise program, heat therapy and transcutaneous electrical nerve stimulation (TENS) unit for pain control. Authorization for left shoulder arthroscopy with rotator cuff repair, labral tear repair, and subacromial decompression was requested with post-op physical therapy, shoulder sling and abductor pillow, and cold therapy unit. The 9/23/14 utilization review denied the requests for cold therapy unit and shoulder sling with abduction pillow because the associated surgery was not certified based on an absence of imaging.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold treatment 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), 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) Shoulder, Continuous flow cryotherapy

Decision rationale: The California Medical Treatment Utilization Schedule (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. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The use of a cold therapy unit would be reasonable for 7 days post-operatively, if the surgery is approved. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request is not medically necessary.

Shoulder sling with abduction pillow, left shoulder: 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), Postoperative Abduction Pillow Sling

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 California Medical Treatment Utilization Schedule (MTUS) guidelines state that the shoulder joint can be kept at rest in a sling if indicated. The Official Disability Guidelines state that post-operative abduction pillow slings are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. There is no evidence that the injured worker has a large or massive rotator cuff tear. Guidelines generally support a standard sling for post-operative use. There is no compelling reason to support the medical necessity of a specialized abduction sling over a standard sling. Therefore, this request is not medically necessary.