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| Case Number: | CM14-0056036 | | |
| Date Assigned: | 07/09/2014 | Date of Injury: | 08/10/2011 |
| Decision Date: | 08/08/2014 | UR Denial Date: | 04/08/2014 |
| Priority: | Standard | Application Received: | 04/25/2014 |

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 and Colorado. 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 48-year-old female who reported an injury on 08/10/2011 after lifting a patient. The injured worker reportedly sustained an injury to her shoulder. The injured worker's treatment history included physical therapy, acupuncture, activity modification, and anti-inflammatory medications. Conservative treatment failed to resolve the injured worker's symptoms. The injured worker was evaluated on 03/05/2014. Physical examination of the right shoulder demonstrated tenderness to palpation over the supraspinatus tendon with decreased range of motion and a positive Hawkin's test. The injured worker's diagnoses included cervical spine herniated nucleus pulposus, lumbar spine herniated nucleus pulposus, right shoulder impingement syndrome/tendinitis, status post Lap-Band procedure and history of gastritis. It was noted that the injured worker was pending authorization for right shoulder surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre Medical Clearance with Labs:

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, ODG, Low Back, Preoperative Testing, General.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, Pre-operative Lab Testing.

Decision rationale: California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines do not recommend routine preoperative labs for ambulatory surgeries. The clinical documentation does not provide any evidence of complicating risk factors for this ambulatory surgery. Therefore, the need for preoperative labs is not indicated in his clinical situation. As such, the requested premedical clearance with labs is not medically necessary or appropriate.

Abduction Pillow/Shoulder Sling: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, Postoperative Abduction Pillow Sling.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Postoperativie abduction pillow sling.

Decision rationale: American College of Occupational and Environmental Medicine does recommend short courses of immobilization for acute pain. It would be expected that there would be a period of acute pain following the planned surgical intervention. However, Official Disability Guidelines recommend the use of an abduction pillow/shoulder sling be reserved for patients who have undergone massive open rotator cuff repair. It is noted within the documentation that the planned surgery is arthroscopic rotator cuff repair. Although a shoulder sling would be indicated in this clinical situation, there is no support for an abduction pillow/shoulder sling. As such, the requested abduction pillow/shoulder sling is not medically necessary or appropriate.

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 Shoulder Chapter, 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 Chapter, Continuous Flow Cryotherapy.

Decision rationale: California Medical Treatment Utilization Schedule does not specifically address this request. Official Disability Guidelines recommend the use of a cold therapy unit to assist with postsurgical pain management for up to 7 days. The request is for purchase of this unit. Guidelines only support a 7 day rental. There are no exceptional factors to support

extending treatment beyond guideline recommendations. As such, the requested cold therapy unit for purchase is not medically necessary or appropriate.