MAXIMUS Federal Services

Case Number:	CM14-0085138		
Date Assigned:	07/23/2014	Date of Injury:	12/02/2005
Decision Date:	08/27/2014	UR Denial Date:	05/07/2014
Priority:	Standard	Application Received:	06/06/2014

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:

This 63-year-old male welder fabricator sustained an industrial injury on 12/2/05, due to cumulative trauma. The 2/28/14 right shoulder MRI revealed complete loss of articular cartilage of the humeral head with femoral head flattening, osteophyte formation, and cystic changes. The rotator cuff was torn at the subscapularis tendon. The 4/17/14 treating physician report cited constant grade 6/10 right shoulder pain with moderate functional limitations. Pain was aggravated by repetitive lifting and upper extremity movement. The patient was unable to work. Right shoulder exam documented moderate to severe shoulder capsule tenderness to palpation, humeral crepitation, and intact motor function. Shoulder range of motion testing documented flexion 120, abduction 60, internal rotation 10, and external rotation 40 degrees. Cross shoulder adduction, empty can, Hawkins's, and impingement tests were positive. The treatment plan requested hemi-arthroplasty, post-operative physical therapy, continuous passive motion, cold therapy, and a shoulder sling. The 5/7/14 utilization review certified the right shoulder hemi-arthroplasty. The request for cold therapy unit was modified and approved for 7 day rental. The request for continuous passive motion was denied as there was no guideline support and provider agreement was documented in the peer-to-peer conversation. The request for a shoulder sling was certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit, rental for seven (7) days, for the right shoulder: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, 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 MTUS are silent regarding Cold Therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery. Postoperative use generally may be 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. Guideline criteria have been met. This request for 7 day rental of a cold therapy unit is consistent with guidelines for use following shoulder surgery. Therefore, this request for Cold Therapy Unit rental for seven (7) days for the right shoulder is medically necessary.

Continuous passive motion for the right shoulder: 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 (CPM).

Decision rationale: The California MTUS does not provide recommendations for this device following shoulder surgery. The Official Disability Guidelines state that Continuous Passive Motion (CPM) is not recommended after shoulder surgery, except in cases of adhesive capsulitis. Guideline criteria have not been met. The routine use of Continuous Passive Motion following shoulder arthroplasty is not recommended. Therefore, this request for Continuous Passive Motion for the right shoulder is not medically necessary.

Shoulder sling: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Post-operative pillow sling.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213.

Decision rationale: The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. Prolonged use of a sling only for symptom control is not recommended. Guideline criteria have been met. The use of a post-operative sling is generally indicated. Therefore, this request for one shoulder sling is medically necessary.