MAXIMUS Federal Services

Case Number:	CM14-0208831		
Date Assigned:	12/22/2014	Date of Injury:	06/26/2013
Decision Date:	03/03/2015	UR Denial Date:	11/14/2014
Priority:	Standard	Application Received:	12/12/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Pennsylvania, Ohio, California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

On 10/08/2014, this patient was seen in comprehensive orthopedic evaluation. The patient was noted to have a right shoulder impingement with osteoarthritis and loose bodies as well as a lumbar sprain and cervical sprain. The treating physician recommended arthroscopy and decompression with removal of loose bodies.An initial physician review of 11/13/2014 notes this patient's diagnoses of right shoulder impingement and lumbar herniation with radiculopathy and notes the patient had findings of right shoulder decreased range of motion with positive provocative testing and pain. That review noted that an ultrasound was not medically necessary except for large rotator cuff tendon tears and noted that there was no medical rationale for specific postoperative exercise kit or for purchase of an interferential stimulator unit. That review also noted there was no medical rationale for a compression unit after a routine shoulder arthroscopy and that a cold therapy unit was not necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

UltraSling for the right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG PostOp 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, UltraSling.

Decision rationale: The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines does not specifically discuss the need for an UltraSling. Official Disability Guidelines/Treatment in Workers Compensation/Shoulder recommends an UltraSling or postoperative abduction pillow sling as an option following large or massive rotator cuff tears. This does not apply in this case. This request is not medically necessary.

Shoulder Exercise Kit for the right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

Decision rationale: The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on Physical Medicine, page 99, recommends transition to an independent home rehabilitation program. Such a program should be individualized. The medical records and the request in this case do not clarify the contents of the proposed shoulder exercise kit. Therefore, this request is not supported by the treatment guidelines. This request is not medically necessary.

Interferential Unit purchase for the right shoulder with 3 month supply of electrodes: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Stimulation Page(s): 118.

Decision rationale: The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on interferential stimulation, page 118, states this is not recommended as an isolated intervention and that it is recommended in selected situations when first-line treatment has failed, such as when pain is ineffectively controlled due to side effects or diminished effectiveness of medication. These situations do not apply at this time. This request is not medically necessary.

Cold Therapy Unit purchase for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Continuous Cryotherapy.

Decision rationale: The California Medical Treatment Utilization Schedule does not specifically discuss using a cold therapy unit. Official Disability Guidelines/Treatment in Workers Compensation/Shoulder does discuss continuous cryotherapy and recommends this for up to 7-day rental, rather than for purchase. Overall, ACOEM guidelines, Chapter 3, Treatment, page 48, recommends the use of low-tech heat and cold, such as ice packs, but does not provide a rationale for purchase of durable medical equipment, such as a cold therapy unit. Thus, the request is not supported by the treatment guidelines. Overall, the request is not medically necessary.