

Case Number:	CM15-0184991		
Date Assigned:	10/23/2015	Date of Injury:	10/01/2013
Decision Date:	12/14/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	09/22/2015

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: Minnesota, Florida
 Certification(s)/Specialty: Orthopedic Surgery

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 59 year old male, who sustained an industrial injury on October 1, 2013, incurring right shoulder and right upper arm injuries. Magnetic Resonance Imaging of the shoulder revealed rotator cuff tendinosis, degeneration and tear. He was diagnosed with a SLAP tear lesion of the right shoulder, right rotator cuff syndrome and right medial and lateral epicondylitis. Treatment included chiropractic sessions, physical therapy, anti-inflammatory drugs, pain medications, steroid injections and activity restrictions. Currently, the injured worker complained of persistent right shoulder pain worsened with overhead reaching. He noted weakness in the shoulder, pain in the elbow and in his wrist. While lying on his right side when sleeping, the pain worsened. He had limited range of motion and weakness of the right shoulder. He was referred for right shoulder surgery. The treatment plan that was requested for authorization included a post-operative abduction sling for the right shoulder, post-operative ice machine for the right shoulder and a Magnetic Resonance Imaging of the right wrist. On September 1, 2015, requests for a sling for the right shoulder, ice machine and Magnetic Resonance Imaging of the right wrist were denied by utilization review. The reason for denial of the abduction sling and ice machine was that the shoulder surgery had been denied and so associated services were not necessary. The MRI of the wrist was denied because conservative treatment had not been tried.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op abduction sling - right 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Postoperative Abduction pillow sling.

Decision rationale: ODG guidelines do not recommend postoperative abduction pillow slings for arthroscopic shoulder surgery. It is recommended as an option following open repair of large and massive rotator cuff tears. In this case, there is no documentation of a large and massive rotator cuff tear. As such, the request for an abduction pillow sling is not supported and the request is not medically necessary.

Post-op ice machine - right 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Continuous flow cryotherapy.

Decision rationale: ODG guidelines recommend continuous-flow cryotherapy as an option after shoulder surgery for 7 days. It reduces pain, swelling, and inflammation and reduces the need for narcotics after surgery. Use beyond 7 days is not recommended. The request as stated does not specify if it is a rental or purchase and does not specify the duration of the rental. As such, the request is not medically necessary.

MRI - right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies.

Decision rationale: With regard to the request for MRI scan of the wrist, California MTUS guidelines recommend 4-6 week period of conservative care and observation prior to the MRI scan. As such, the medical necessity of the MRI scan is not established. The request is not medically necessary.