

Case Number:	CM15-0209246		
Date Assigned:	10/28/2015	Date of Injury:	05/05/2015
Decision Date:	12/08/2015	UR Denial Date:	10/12/2015
Priority:	Standard	Application Received:	10/23/2015

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: Illinois, California, Texas
 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:

This injured worker is a 58-year-old male who sustained an industrial injury on 5/5/14. Injury occurred when he tried to close a window in the train cab and experienced a pop in his right shoulder. Past medical history was negative. Conservative treatment included medication management, physical therapy, corticosteroid injection, and activity modification. The 9/14/15 right shoulder MRI impression documented a partial thickness tear of the distal supraspinatus tendon, mild diastasis of the acromioclavicular (AC) joint, and small cysts/geodes in the greater tuberosity of the humeral head. The 10/1/15 treating physician report cited worsening grade 7/10 right shoulder pain associated with weakness and loss of motion. Functional difficulty was noted with overhead activities and sleeping. Physical exam documented mild tenderness to palpation over the right AC joint and pain with cross body adduction. Active range of motion was 110-100-20 degrees; passive range of motion was 160-160-40 degrees. Neer, Hawkin's, and Speed's tests were positive. He had 3/5 supraspinatus and 4/5 external rotation strength. X-rays showed mild diastasis and undersurface spurring at the AC joint. Imaging showed a high-grade, near full thickness, tear of the supraspinatus with mild increased AC joint space consistent with a grade 1-2 AC joint sprain. There was evidence of subacromial bursitis and bicipital tenosynovitis. He was not capable of regular work. He had failed extensive conservative treatment. Authorization was requested for right shoulder arthroscopy with subacromial decompression, distal clavicle excision, rotator cuff repair, and possible biceps tenodesis and associated services, including purchase of a Polar Care unit and an Ultra-sling. The 10/12/15 utilization review certified the right shoulder surgery. The request for Polar Care unit purchase was modified to 7-day rental

consistent with the Official Disability Guidelines. The request for an Ultra-sling purchase was non-certified as the medical necessity of this specific sling was not established or supported by the Official Disability Guidelines for a small rotator cuff tear.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical services: Polar care unit (purchase): Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Continuous-flow cryotherapy, Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold; <http://www.breg.com/products/cold-therapy/devices/polar-care-glacier>.

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 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. The 10/12/15 utilization review decision recommended partial certification of a cold therapy unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.

Associated surgical services: Ultra sling (purchase): 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 Chapter, <http://www.djoglobal.com/products/donjoy/ultrasling>.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Activity Modification. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling.

Decision rationale: The California MTUS is silent regarding post-op abduction pillow slings. The Official Disability Guidelines state that these slings are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. This patient has high-grade partial thickness to near full thickness rotator cuff tear and arthroscopic repair is planned. 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 for is not medically necessary.