

Case Number:	CM15-0020090		
Date Assigned:	02/09/2015	Date of Injury:	02/03/2012
Decision Date:	03/31/2015	UR Denial Date:	01/13/2015
Priority:	Standard	Application Received:	02/03/2015

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: Arizona, Texas
 Certification(s)/Specialty: Internal Medicine

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 52-year-old male, who sustained an industrial injury on 2/3/12. He has reported head and bilateral shoulder injury after getting hit on the head by a metal basket working as a torque operator. The diagnoses have included strain of cervical spine, impingement syndrome right and left shoulder with bursitis and tendinitis, and osteoarthritis of the acromioclavicular joint. Treatment to date has included medications, diagnostics, cortisone injections, physical therapy 12 visits and conservative measures. Currently, the injured worker complains of pain in the right and left shoulders with left worse than right. He can't do any lifting, pulling or pushing. Magnetic Resonance Imaging (MRI) of the left shoulder revealed osteoarthritis of the acromioclavicular joint and tendinitis. Physical exam of the shoulders revealed tenderness, positive impingement sign, Neer's sign, and thumbs down test in the left shoulder. There was decreased range of motion in the left shoulder. It was documented that the injured worker had failed conservative treatments. Request was for left shoulder arthroscopic examination and arthroscopic surgery with request for Cold therapy unit for purchase and request for Ultrasling purchase. There were no documented sessions of physical therapy noted. Work status was temporary totally disabled. On 1/13/15 Utilization Review modified a request for Cold therapy unit for purchase modified to Cold therapy unit certified for 7 day trial, noting that continuous cold therapy is recommended in the first 7 days post operative. It has been found to reduce pain, inflammation and opiate use. The (MTUS) Medical Treatment Utilization Schedule and (ACOEM) Occupational Medicine Practice Guidelines were cited. On 1/13/15 Utilization Review non-certified a request for Ultrasling purchase, noting that it is recommended as an

option following open repair of large or massive rotator cuff tears. The (MTUS) Medical Treatment Utilization Schedule and (ACOEM) Occupational Medicine Practice Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit for purchase: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder (updated 10/31/14), continuous-flow cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation shoulder

Decision rationale: Continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. 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. In this case the patient has the diagnosis of impingement syndrom of bilateral shoulders, subacromial bursitis and rotator cuff tendenosis. A left shoulder arthroscopic decompression is planned. Given the fact that surgery is planned and cryotherapy is recommended the use of a home system is medically appropriate.

Ultrasling purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder (updated 10/31/14), post operative abduction pillow sling

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder

Decision rationale: Postoperative abduction pillow sling is recommended as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. In this case the patient has the diagnosis of impingement syndrom of bilateral shoulders, subacromial bursitis and rotator cuff tendenosis. A left shoulder arthroscopic decompression is planned. Therefore, this is not medically necessary.