MAXIMUS Federal Services

Case Number:	CM15-0031315		
Date Assigned:	02/24/2015	Date of Injury:	05/24/2012
Decision Date:	04/03/2015	UR Denial Date:	01/29/2015
Priority:	Standard	Application Received:	02/19/2015

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:

The injured worker is a 52-year-old female, who sustained an industrial injury on 5/24/12, due to repetitive office work. Past surgical history was positive for left carpal tunnel release on 9/22/14. The 11/20/14 left shoulder MRI impression documented diffuse thickening and severe tendinosis versus advanced degeneration of the distal supraspinatus and infraspinatus tendons with probable partial thickness tears. There was milder subscapularis and biceps tendinosis. There was narrowing of the glenohumeral joint space with attenuation of the articular cartilage, and mild to moderate acromioclavicular joint arthrosis. Findings were suggestive of degeneration with a probable anterior superior labral tear. The 12/11/14 orthopedic report cited persistent right shoulder pain with inability to reach and perform overhead activities. Physical exam documented guarding over both shoulders and passive range of motion limited to flexion 110 degrees, abduction 70 degrees, and internal rotation to L5 bilaterally. There was 4/5 left abduction weakness with severe pain. Reverse O'Briens and drop arm tests were positive on the left. The patient had failed over 6 months of conservative treatment including physical therapy, and injections in the past. The treatment plan recommended left shoulder subacromial decompression, Mumford, and rotator cuff repair. On 1/29/15, utilization review non-certified the request for smart sling with abduction pillow and cold therapy unit as the associated surgical request was non-certified and citing Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Smart Sling with Abduction Pillow: 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), Treatment Index, 11th Edition (web), 2014, Shoulder, Postoperative abduction 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, Postoperative abduction pillow sling.

Decision rationale: The California MTUS are 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. There is no evidence of a massive rotator cuff tear or a current recommendation for open rotator cuff repair. There is no compelling reason to support the medical necessity of a specialized abduction sling over a standard sling for post-op use. Therefore, this request is not medically necessary.

Cold Therapy: 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), Treatment Index, 11th Edition (web), 2014, Shoulder, 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 shoulder surgery for up to 7 days, including home use. The use of a cold therapy unit would be reasonable for 7 days following the proposed surgery. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request is not medically necessary.