MAXIMUS Federal Services

Case Number:	CM15-0056286		
Date Assigned:	04/01/2015	Date of Injury:	09/23/2004
Decision Date:	05/12/2015	UR Denial Date:	03/18/2015
Priority:	Standard	Application Received:	03/24/2015

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 57 year old female who sustained a work related injury September 23, 2004. According to a primary treating physician's progress report, dated March 9, 2015, the injured worker presented for follow-up of her left shoulder MRI scan. She complains of pain in her left shoulder which increased with overhead reaching. An MRI of the left shoulder, dated February 12, 2015, revealed deep partial rotator cuff tear, left shoulder, degenerative arthritis, s/p SLAP repair, 2005. An MR Arthrography report, dated February 27, 2015, is present in the medical record. Treatment plan included request for authorization for left shoulder arthroscopy, chondroplasty, removal of loose bodies and possible rotator cuff repair, assistant surgeon, post-operative physical therapy, ultra sling, contrast compression unit/thermacure x 7 day rental, purchase pad, pre-operative medical clearance. Utilization Review certified the surgical request and modified some of the associated surgical requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy, chondroplasty, removal of loose bodies and possible rotator cuff repair, will also evaluate and treat any other intra-articular pathology such as partial biceps tendon tear: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Shoulder Procedure Summary, Arthroscopy, Rotator cuff repair.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211.

Decision rationale: The request for arthroscopy of the left shoulder with chondroplasty, removal of loose bodies, and possible rotator cuff repair has been certified by Utilization review and is supported by CA MTUS and ODG guidelines. ODG guidelines recommend arthroscopic debridement of shoulder arthritis with removal of loose bodies upon failure of conservative treatment. As such the request is appropriate and medically necessary.

Associated Surgical Service: Ultra sling purchase: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Shoulder Procedure summary, Postoperative abduction pillow sling.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG; Section: Shoulder, Topic: Post-operative abduction pillow slings.

Decision rationale: ODG guidelines recommend abduction pillow slings as an option after open repair of large or massive rotator cuff tears. The injured worker is not undergoing such repair. However, she has made a special request for an UltraSling as she found it more comfortable in the past. The Ultraslings are adjustable and control rotation, providing more comfort after surgery. The degree of abduction can also be controlled. Considering the special request from the injured worker, and the need for comfort, the use of an ultrasling is appropriate and medically necessary.

Associated Surgical Service: Contrast compression unit/Thermacure - rental 7 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Shoulder Procedure Summary, Continuous-flow cryotherapy.

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

Decision rationale: ODG guidelines recommend continuous flow cryotherapy after shoulder surgery for 7 days. It reduces pain, swelling, inflammation, and need for narcotics. Cold compression is not recommended for the shoulder. As such, the request for contrast compression unit/ Thermacure rental for 7 days is not supported and the medical necessity is not established.

The modification of the request to continuous flow cryotherapy for 7 days rental is appropriate and medically necessary.