

Case Number:	CM15-0085404		
Date Assigned:	05/07/2015	Date of Injury:	02/11/2008
Decision Date:	06/11/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	05/04/2015

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: Texas, California
 Certification(s)/Specialty: Family Practice

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 61-year-old male who sustained a work related injury February 11, 2008. According to a primary treating physician's progress report, dated March 17, 2015, the injured worker presented for follow-up of his neck and bilateral shoulder pain, specifically the left shoulder. The physician noted, a left shoulder arthroscopy, subacromial decompression, acromioclavicular joint decompression, and repair of the labrum and/or rotator cuff was denied. Examination of the left shoulder continues to show evidence of impingement. There is weakness with external rotation and abduction, range of motion is limited. Diagnoses included left shoulder rotator cuff tear; left shoulder impingement syndrome; left shoulder rotator cuff tendinitis; left shoulder labral tear; left shoulder acromioclavicular joint arthritis; cervical spine degeneration; right shoulder impingement syndrome; right shoulder rotator cuff tear s/p arthroscopy and repair. At issue, is the request for CPM (continuous passive motion) left shoulder, Polar unit, and sling. The patient has used a TENS unit. Patient has received an unspecified number of PT visits for this injury. The medication list include Flexeril, naproxen and Tramadol. The patient sustained the injury due to cumulative trauma. The patient has had MRI of then left shoulder that revealed rotator cuff disease and impingement syndrome. Any operative note was not specified in the records provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Sling for left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (updated 05/04/15) Postoperative abduction pillow sling.

Decision rationale: Sling for left shoulder. ACOEM and CA MTUS chronic pain guidelines do not address this request. Therefore ODG was used. As per cited guideline, "Postoperative abduction pillow sling: 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." (Ticker, 2008) The physician noted, a left shoulder arthroscopy, subacromial decompression, acromioclavicular joint decompression, and repair of the labrum and/or rotator cuff was denied. Any surgery or procedures related to this injury were not specified in the records provided. Any operative note was not specified in the records provided. Any evidence that the patient was certified for a left shoulder surgery was not specified in the records provided. In addition as per cited guideline, the immobilization devices decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. The medical necessity of the request for Sling for left shoulder is not fully established for this patient.

CPM for left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (updated 05/04/15) Continuous passive motion (CPM).

Decision rationale: CPM for left shoulder. ACOEM and CA MTUS chronic pain guidelines do not address this request. Therefore ODG was used. As per cited guideline, "Continuous passive motion (CPM): Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week." Rotator cuff tears: Not recommended after shoulder surgery or for nonsurgical treatment. The physician noted, a left shoulder arthroscopy, subacromial decompression, acromioclavicular joint decompression, and repair of the labrum and/or rotator cuff was denied. Any surgery or procedures related to this injury were not specified in the records provided. Any operative note was not specified in the records provided. Any evidence that the patient was certified for a left shoulder surgery was not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. Detailed response to previous conservative therapy was not specified in the records provided. The medical necessity of the request for CPM for left shoulder is not fully established for this patient.

Polar unit for the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder

Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back (updated 05/12/15) Heat/cold applications Shoulder (updated 05/04/15) Continuous-flow cryotherapy.

Decision rationale: Polar unit for the left shoulder. Per the cited guidelines, "Patients at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. Rationale for not using simple hot/cold packs versus the use of this DME is not specified in the records provided. Per the cited guidelines, Insufficient testing exists to determine the effectiveness (if any) of heat/cold applications." As per cited guideline, "Continuous-flow cryotherapy: Recommended as an option after surgery, but not for nonsurgical treatment." The physician noted, a left shoulder arthroscopy, subacromial decompression, acromioclavicular joint decompression, and repair of the labrum and/or rotator cuff was denied. Any surgery or procedures related to this injury were not specified in the records provided. Any operative note was not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. Detailed response to previous conservative therapy was not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The medical necessity of the request for Polar unit for the left shoulder is not fully established in this patient.