

Case Number:	CM14-0111084		
Date Assigned:	08/01/2014	Date of Injury:	10/20/2011
Decision Date:	10/06/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	07/16/2014

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 54 year old male who was injured on 10/20/2011. The mechanism of injury was a trip and fall. Records reference an MRI of the left shoulder dated 07/15/13 which reportedly shows a partial tear of the insertion of supraspinatus tendon. The injured worker is diagnosed with left shoulder sprain/strain and supraspinatus tear. The injured worker complains of left shoulder pain with numbness and tingling. Treatment has consisted of physical therapy and a left shoulder injection. The injured worker continued to complain of constant left shoulder pain and upon physical examination dated 06/05/14 the injured worker demonstrated decreased flexion to 140 degrees with pain and positive Neer, Hawkins, Jobe and Cross Adducting tests, tenderness to palpation over the superior greater than posterior aspect of the left shoulder. Clinical note dated 07/17/14 states authorization has been received for left shoulder surgery and notes surgery is scheduled for 08/25/14. A request is submitted for a postoperative sling and postoperative rental of a cold unit for ten days. The request for the rental of the cold therapy unit is modified for approval for seven days per guideline recommendations and the request for a postoperative sling was denied by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post Operative sling: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter, Immobilization

Decision rationale: Current evidence based guidelines do not support the use of immobilization for extended periods of time. Official Disability Guidelines (ODG) states, with the shoulder, immobilization is also a major risk factor for developing adhesive capsulitis, also termed frozen shoulder. As guidelines do not support the use of this modality, medical necessity of a postoperative sling is not established.

Post Operative rental cold unit x10 days: Upheld

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

Decision rationale: Official Disability Guidelines (ODG) states the use of continuous flow cryotherapy, such as a cold unit, is recommended as an option after surgery. This guideline states, postoperative use generally may be up to seven days, including home use. As guidelines only support the use of such a device for seven days, the request exceeds guideline recommendations. There are no exceptional factors submitted for review which warrant treatment in excess of guideline recommendations. Based on the clinical information provided, medical necessity of the post operative rental cold unit ten days is not established.