

Case Number:	CM14-0149548		
Date Assigned:	09/18/2014	Date of Injury:	03/25/2000
Decision Date:	10/17/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/15/2014

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 Emergency 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:

Patient with reported date of injury on 3/25/2000. Mechanism of injury was not provided for review. Patient has a diagnosis of L shoulder impingement syndrome, insomnia and depression. Patient is post R shoulder arthroscopy done in 2000, acromioplasty and Mumford procedure on 1/21/10 and distal clavicle excision and bursectomy on 3/2011. Medical reports reviewed. Last report available until 8/1/14. Patient complains of Right shoulder pain. Pain is limiting ability to work. Objective exam reveals tenderness along L shoulder, rotator cuff and biceps tendon. Abduction to 120degrees with mild weakness due to pain. Positive Impingement and cross arm test. There is significant issue with documentation. Progress note dated 8/1/14 from Nurse Practitioner and Physician contradict each other. Notes states that patient complains of R shoulder but many notes refer to L shoulder exam. MRI documentation in the progress notes does not state which site has the labral tear. The notes also contradict each other on which side had prior surgery with NP stating the left side while the treating physician states right side. Prior notes are clearer and refer to R shoulder. MRI of shoulder reportedly done on 8/1/14(R side) reveals labral fraying, partial rotator cuff tear along supraspinatus. Medication list was not provided but include Terocin and Lidopro. Reportedly on opioids and muscle relaxants. Prior notes state that it is Norco and soma. Patient has reportedly undergone physical therapy, hot and cold wraps, home exercise, TENS, injections and medications. Independent Medical Review is for "Polar Care" 21day rental and R shoulder immobilizer (8/7/14). Prior UR on 8/21/14 recommended non-certification. UR during that also denied R shoulder surgery and multiple other requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

Polar Care 21 day rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, KNEE AND LEG

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Shoulder(Acute and Chronic)>, <Continuous-Flow Cryotherapy>

Decision rationale: UR on 8/21/14 denied surgery. There is no other documentation that surgery was approved. MTUS Chronic Pain and ACOEM guidelines only have vague recommendations concerning icing post surgery and do not provide information to make an evidenced based recommendations. As per Official Disability Guide(ODG), continuous flow cryotherapy is recommended as a post-surgical option as it may decrease inflammation, pain and swelling. ODG only recommends up to 7days of use. However, there is no approved surgery. Polar Care is not medically necessary.

Shoulder immobilizer for the right shoulder per form dated 08/07/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. 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>, <Immobilization>

Decision rationale: UR on 8/21/14 denied surgery. There is no other documentation that surgery was approved. MTUS Chronic Pain and ACOEM guidelines do not have any specific section that deals with this topic. The shoulder immobilizer was requested for post-operative care and not for chronic shoulder pain. Official Disability Guidelines(ODG) do not recommend immobilization. Postoperative Abduction pillow is sometime recommended for post-surgery but surgery has not been approved. Shoulder immobilizer is not medically necessary.