

Case Number:	CM14-0162334		
Date Assigned:	10/07/2014	Date of Injury:	02/28/2007
Decision Date:	11/04/2014	UR Denial Date:	09/29/2014
Priority:	Standard	Application Received:	10/02/2014

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 Orthopedic Surgery, 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:

This 55-year-old male sustained an industrial injury on 2/28/07. The mechanism of injury was not documented. Past surgical history was positive for left shoulder arthroscopic subacromial decompression, rotator cuff repair, and distal clavicle excision on 3/14/13 and left shoulder arthroscopic extensive debridement and capsulotomy with removal of intraarticular suture material, lysis of adhesions, rotator cuff repair, and manipulation under anesthesia on 10/3/13. The 8/11/14 right left shoulder MRI impression documented no rotator cuff tear, moderate supraspinatus tendinosis, and mild degenerative tearing of the superior labrum. There was mild proximal long biceps tendinosis with interstitial degeneration extending into the biceps anchor. The 9/19/14 progress report cited continued left shoulder pain, worsened with forward lifting when the arm was forward flexed. A previous shoulder injury provided only temporary relief. Oral medications provided partial temporary symptomatic relief. Left shoulder physical exam documented good range of motion with pain in forward flexion. There was tenderness to palpation over the anterior shoulder with positive Speed's test. There was no crepitus or instability. The patient showed good progress after the previous arthroscopic surgery treatment of the left shoulder but developed increased pain with physical therapy exercises. Clinical presentation was consistent with a SLAP tear and probable biceps tendon symptoms with slight flexion weakness on exam. Given failure of conservative treatment, authorization for arthroscopic evaluation and repair with probable biceps tenodesis was requested. The 9/29/14 utilization review denied the request for purchase of a cold therapy unit and abduction sling as the associated surgery was not approved.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase for a cold therapy unit: 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) Shoulder Chapter 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 post-operatively should this surgery be approved. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request is not medically necessary.

Purchase for an abduction sling: 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) Shoulder Chapter Postoperative abduction sling pillow

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, 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. Guideline criteria have not been met. This patient does not present with a rotator cuff tear. Guidelines generally support a standard sling for post-operative use. There is no compelling reason to support the medical necessity of a specialized abduction sling over a standard sling. Therefore, this request is not medically necessary.