

Case Number:	CM14-0093650		
Date Assigned:	09/12/2014	Date of Injury:	01/11/2006
Decision Date:	10/07/2014	UR Denial Date:	06/02/2014
Priority:	Standard	Application Received:	06/20/2014

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 Orthopaedic 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 female packer sustained an industrial injury on 1/11/06 relative to a trip and fall. She was diagnosed with a comminuted fracture of the distal radius, fracture of the ulnar styloid process, chip or avulsion fracture of the lunate, and possible triangular fibrocartilage complex (TFCC) tear. Multiple requests for surgery to the shoulders and wrist are noted in the file since 2006 with no evidence of prior surgery. The 5/15/14 treating physician report cited continued complaints of bilateral shoulder pain with difficulty performing tasks above shoulder height and pain at night, and bilateral wrist pain and weakness. Shoulder exam documented no swelling or effusion, and tenderness over the biceps tendon/groove, suprascapular muscles, and supraspinatus tendons bilaterally. Range of motion was flexion 130, abduction 130, and external/internal rotation 40 degrees bilaterally. Rotator cuff strength was 4/5 bilaterally. Hand and wrist exam documented positive swelling and effusion, mild deformity and atrophy. There was significant tenderness over the ulna styloid and TFCC. Wrist flexion, extension, and ulnar deviation were slightly decreased. Strength and sensation were intact. There was mild subluxation over the ulnar styloid. The diagnosis included bilateral shoulder impingement syndrome with bursitis, tendonitis, and partial rotator cuff tear, left worse than right, and left wrist sprain/strain with injury to the TFCC. The treatment plan recommended bilateral shoulder arthroscopic decompression with possible Mumford procedure. The patient had failed all conservative modalities and had a positive MRI for impingement. Left wrist arthroscopic debridement was also recommended for MRI findings of a TFCC ligament tear and synovitis. The 6/2/14 utilization review denied the requests for a post-op Ultra Sling and cold therapy unit as the associated surgery had not been certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultra 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), Treatment Index, 11th Edition (web), 2013-Shoulder Chapter-Cryotherapy, postoperative Abduction Pillow Sling

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, Postoperative abduction pillow sling

Decision rationale: The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. The Official Disability Guidelines state that post-operative abduction pillow slings, like the Ultra Sling, are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. An open massive rotator cuff repair has not been requested. 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.

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), Treatment Index, 11th Edition (web), 2013-Shoulder Chapter-Cryotherapy, postoperative Abduction Pillow Sling

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 surgery for up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request is not medically necessary