MAXIMUS Federal Services

Case Number:	CM14-0119309		
Date Assigned:	08/06/2014	Date of Injury:	10/26/2012
Decision Date:	03/30/2015	UR Denial Date:	07/16/2014
Priority:	Standard	Application Received:	07/28/2014

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. 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: Minnesota, Florida
Certification(s)/Specialty: Orthopedic Surgery

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 63 year old male, who sustained an industrial injury on 10/26/2012. The diagnoses have included shoulder osteoarthrosis. Treatment to date has included physical therapy and pain medications. The injured worker underwent a left shoulder arthroscopic biceps tenodesis, debridement of labral tear, subacromial decompression and distal clavicle excision on 10/28/2013. Left shoulder x-ray from 6/4/2014 revealed recurrent degenerative changes of the left acromioclavicular (AC) joint. According to the progress noted dated 7/2/2014, the injured worker had persistent left shoulder pain. An injection had been given at the prior visit on 6/4/2014. The injured worker reported the injection was painful for the first two weeks, but after the last two weeks it had been improving. He rated his pain as 3/10 to 5/10. Shoulder exam revealed tenderness at the acromioclavicular (AC) joint. He essentially had full range of motion but had positive impingement signs. Further surgery was recommended including subacromial decompression and resection of the lateral clavicle. Equipment need included and ice therapy unit and a shoulder immobilizer. On 7/16/2014 Utilization Review (UR) non-certified a request for a Left Shoulder Immobilizer and Ice Therapy Unit. No guideline was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Immobilizer: 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 Page(s): 205.

Decision rationale: California MTUS guidelines indicate shoulder disorders may lead to joint stiffness more often than other joint disorders. Because patients with shoulder disorders tend to have stiffness followed by weakness and atrophy,careful advice regarding maximizing activities within the limits of symptoms is imperative. If indicated the joint can be kept at rest in the sling. Gentle exercise even during this time is desirable. The surgical procedure is a revision arthroscopic subacromial decompression and revision lateral clavicle resection for impingement. As such, use of a sling is appropriate with early physical therapy. Immobilization is not recommended. The request for a shoulder immobilizer is therefore not supported by guidelines, and as such, the medical necessity is not established.

Ice Therapy Unit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Section: Shoulder, Topic: Continuous flow cryotherapy

Decision rationale: With regard to the ice therapy unit, ODG guidelines indicate continuous-flow cryotherapy is an option after surgery for 7 days. It reduces pain, inflammation, swelling, and need for narcotic medications after surgery. Use beyond 7 days is not recommended. As such, a 7 day rental is appropriate. The request as stated does not specify if it is for purchase or rental and does not specify the duration of the rental. Therefore the medical necessity of the request is not established.