

Case Number:	CM14-0170361		
Date Assigned:	10/20/2014	Date of Injury:	04/01/2008
Decision Date:	05/13/2015	UR Denial Date:	10/02/2014
Priority:	Standard	Application Received:	10/15/2014

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. 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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 43-year-old female who reported an injury on 04/01/2008. The mechanism of injury was a fall. Her diagnoses include left shoulder impingement and partial rotator cuff tear. Her past treatment has included medications, activity modification, and physical therapy. The injured worker was seen for a preoperative evaluation on 08/12/2014 as it was noted she was scheduled for left shoulder surgery on 08/20/2014. The physical examination findings are illegible. The treatment plan was to proceed with surgical intervention followed by postoperative treatment. However, details regarding the recommended postoperative treatment and rationale were not provided. Requests were received for an ARS pad/wrap, shoulder exercise kit, an UltraSling, and a hot/cold compression device.

IMR ISSUES, DECISIONS AND RATIONALES

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

ARS-Pad/Wrap for the Left Shoulder: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Shoulder Exercise Kit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47.

Decision rationale: According to the California MTUS Guidelines, exercise programs are recommended as a strong evidence that treatment programs that include exercise are superior to programs that do not include exercise. However, the guidelines state there is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. The clinical information submitted for review indicated that the injured worker was scheduled for left shoulder surgery on 08/20/2014. A request was made for a shoulder exercise kit. While exercise following her shoulder surgery is appropriate per the guidelines, the guidelines do not support 1 exercise over another. Therefore, a specific exercise kit is not supported. In addition, the documentation does not provide details regarding the exercise kit, what is included, and how it would be beneficial over a standard home exercise program. As such, the request is not medically necessary.

Ultra Sling for the Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling.

Decision rationale: According to the Official Disability Guidelines, use of a postoperative abduction pillow sling is only recommended following open repair of large, massive rotator cuff tears. The clinical information submitted for review indicated that the injured worker was to undergo surgery for a partial thickness rotator cuff tear. Therefore, a postoperative sling is not supported by the guidelines as specialty slings are only recommended for large, massive rotator cuff tears, which have been repaired by open surgery. As such, the request is not medically necessary.

ARS-Hot/Cold Compression for the Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Cold compression therapy; Continuous-flow cryotherapy.

Decision rationale: According to the Official Disability Guidelines, cold compression therapy units are not recommended in the shoulder, as there are no published studies supporting this treatment. However, this treatment may be an option for other body parts. The Official Disability Guidelines state postoperative use of a continuous flow cryotherapy unit is recommended for 7 days only after surgery. The clinical information submitted for review indicated that the injured worker underwent left shoulder surgery on 08/20/2014. Therefore, use of a continuous flow cryotherapy device would have been appropriate for 7 days after surgery. However, the request as submitted does not specify that the treatment is planned for only 7 days. In addition, the guidelines specifically state that compression cold therapy devices are not recommended in the shoulder at this time due to lack of evidence of efficacy. For these reasons, the request is not medically necessary.