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| Case Number: | CM15-0033930 | | |
| Date Assigned: | 02/27/2015 | Date of Injury: | 03/16/2013 |
| Decision Date: | 05/07/2015 | UR Denial Date: | 01/28/2015 |
| Priority: | Standard | Application Received: | 02/23/2015 |

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 53-year-old male who reported an injury on 03/16/2013. The mechanism of injury was not specifically stated. The current diagnoses include status post industrial right shoulder injury and status post right shoulder rotator cuff repair on 05/01/2014. The latest physician progress report submitted for this review is documented on 09/08/2014. The injured worker presented for an orthopedic re-evaluation following a rotator cuff repair, decompression, and distal clavicle resection. Upon examination, there were no signs of infection. The injured worker tolerated 0 to 155 degree active forward flexion, forward elevation, and abduction. There was excellent internal and external rotation, and 4/5 motor strength. Recommendations at that time included continuation of the formal supervised physiotherapy once per week for 6 weeks. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit for an initial period of 90 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder Procedure Summary.

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

Decision rationale: California MTUS Guidelines state continuous flow cryotherapy is recommended for up to 7 days, including home use. It is recommended only following surgical intervention. In this case, it was noted that the injured worker was issued authorization for a revision right shoulder surgery in 01/2015. However, the request for a 90 day rental of a cold therapy unit exceeds guideline recommendations. Therefore, the request is not medically appropriate.

E-stim for an initial period of 90 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: California MTUS Guidelines state postoperative TENS therapy is recommended as a treatment option for acute postoperative pain during the first 30 days following surgery. A rental is preferred over purchase during the 30 day period. The current request for an E-stim unit for a period of 90 days would exceed guideline recommendations. The medical necessity has not been established. Given the above, the request is not medically appropriate.

Purchase of sling with large abduction pillow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder Procedure Summary.

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

Decision rationale: The Official Disability Guidelines recommend a postoperative abduction pillow sling as an option following open repair of a large and massive rotator cuff tear. In this case, the injured worker does not appear to meet criteria for the requested durable medical equipment. There is no indication that this injured worker is scheduled for an open repair of a large or massive rotator cuff tear. Given the above, the request is not medically appropriate.

CPM unit for an initial period of 45 days: 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 Procedure Summary and Blue Cross of California Medical Policy: Continuous Passive Motion Devices.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Continuous passive motion.

Decision rationale: The Official Disability Guidelines state continuous passive motion is not recommended for shoulder rotator cuff problems, but is recommended as an option for adhesive capsulitis for up to 4 weeks/5 days per week. In this case, the request for a 45 day rental would exceed guideline recommendations. Additionally, there is no evidence of adhesive capsulitis. Given the above, the request is not medically appropriate.