

Case Number:	CM15-0094947		
Date Assigned:	05/21/2015	Date of Injury:	12/18/2013
Decision Date:	07/01/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	05/17/2015

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, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 51 year old male, who sustained an industrial injury on 11/4/2009-12/18/2013. He reported continuous trauma of the neck, back, and bilateral shoulders. The injured worker was diagnosed as having rotator cuff tendinosis, and left shoulder pain. Treatment to date has included medications, 24 physical therapy sessions, 24 chiropractic visits, x-rays, and medication management, left shoulder surgery (2009), epidurals, magnetic resonance imaging of the left shoulder (1/8/2015)m and 12 acupuncture sessions. The request is for an ultrasling for the left shoulder, continuous passive motion machine for the left shoulder, and cold therapy unit for the left shoulder. On 3/9/2015, he complained of frequent slight of intermittent neck pain he rated 3/10, and left shoulder slight to intermittently severe pain rated 9/10. He reported increased pain to the left shoulder, right shoulder, neck and low back when attending to his activities of daily living. He also reported trouble with restful sleep. Physical examination revealed the cervical spine to have no deformity, and moderate tenderness is noted to the paracervical muscles. The shoulders showed no deformities or atrophy. Cervical range of motion is limited by 30%, motor strength of the left shoulder is 4 on forward flexion, 4 on abduction, and 4 on external rotation. The range of motion of the left shoulder/normal: forward flexion 150/180, abduction 150/180, external rotation (in Abd) 70/90, external rotation (at side) 70/60, and internal rotation (behind back) T10/T8. There is positive testing on the left shoulder with Neer Impingment, Hawkins Impingment, and Jobe. On 4/23/2015, a handwritten PR-2 refers to the neck and left shoulder. Treatment recommendations included: psychiatric consultation and

treatment, left shoulder revision surgery, and continued home exercises for the neck. Several pages of the medical records contain handwritten information that is difficult to decipher.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasling for the left shoulder: Overturned

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, Postoperative abduction pillow sling.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

Decision rationale: The patient presents with bilateral shoulder and neck pain. The current request is for Ultrasling for the left shoulder. The report with this request was not submitted for review. The treating physician documents that there is a current request for the patient to have surgery on the left shoulder for decompression, distal clavicle resection, and possible rotator cuff repair (49B), however; a left shoulder MRI dated January 2015 did not show a rotator cuff tear. The ACEOM guidelines allow slings for acute pain and for rotator cuff tears they allow a sling for comfort. In this case, the treating physician has documented that the patient has pain in the left shoulder which ACOEM would support a sling for. The current request is medically necessary and the recommendation is for authorization.

Continuous passive motion machine for the left shoulder: 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, Continuous passive motion.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder chapter, Continuous passive motion.

Decision rationale: The patient presents with bilateral shoulder and neck pain. The current request is for continuous passive motion machine for the left shoulder. The treating physician documents that there is a current request for the patient to have surgery on the left shoulder for decompression, distal clavicle resection, and possible rotator cuff repair (49B), however; a left shoulder MRI dated January 2015 did not show a rotator cuff tear. The MTUS guidelines do not address Continuous Passive Motion treatment. The ODG states that CPM is not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. The guidelines do not support the use of CPM except in the case of adhesive capsulitis. While the IW has adhesive capsulitis, and if clinically significant, should be addressed during surgery and should not be present after surgery. The current request is not medically necessary and the recommendation is for denial.

Cold therapy unit for the left shoulder: 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, Online Version, Continuous-flow cryotherapy.

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

Decision rationale: The patient presents with bilateral shoulder and neck pain. The current request is for Cold therapy unit for the left shoulder. The treating physician documents that there is a current request for the patient to have surgery on the left shoulder for decompression, distal clavicle resection, and possible rotator cuff repair (49B), however; a left shoulder MRI dated January 2015 did not show a rotator cuff tear. The MTUS guidelines do not address Cold Therapy Unit (CTU). The ODG guidelines state that continuous flow cryotherapy is recommended as an option following shoulder surgery for up to 7 days. In this case, the request is for a cold therapy unit for unknown duration. There is no documentation that the proposed surgery has been authorized and ODG only supports CTU usage for up to 7 days. The current request for CTU of unknown duration is not medically necessary and the recommendation is for denial.