

<b>Case Number:</b>	CM13-0040559		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	05/14/2013
<b>Decision Date:</b>	05/15/2014	<b>UR Denial Date:</b>	10/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/10/2013

### 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 Anesthesiology, has a subspecialty in Pain Medicine, and is licensed to practice in Florida. 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:

The injured worker is a 35-year-old male who reported an injury on 05/14/2013 due to a crush injury while performing normal job duties. The injured worker reportedly sustained an injury to his left shoulder and upper extremity that resulted in a wound that was treated with specialized care for 4 weeks. The injured worker was treated with extensive physical therapy. The injured worker was evaluated on 08/23/2013. It was documented the injured worker had continued pain complaints rated 8/10 to 9/10. It was noted the injured worker's treatment history included extensive wound care due to a severe infection related to the industrial injury and extensive physiotherapy with a chiropractor. Physical examination revealed severely restricted range of motion of the left shoulder secondary to frozen shoulder syndrome with severely restricted range of motion of the left shoulder and left elbow with numbness over the 5th and 4th digits. The injured worker's diagnoses included grade II to grade III acromioclavicular separation, minimally displaced scapula fracture, severe shoulder crush injury, infected hematoma of the left humerus being treated with a Wound VAC, arthrofibrosis of the left elbow with severe lack of terminal extension, arthrofibrosis of the left shoulder with severe clinically frozen shoulder, arthrofibrosis of the left wrist and hand with inability to make a fist, cervical spine sprain/strain, and ulnar nerve entrapment of the left elbow. The injured worker's treatment plan included continued physiotherapy secondary to the injured worker's special circumstances and severe injury, continuation of wound care as the injured worker continues to have a wound face, and the use of a hot/cold therapy unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**WOUND CARE 3 X 4 WEEKS:** Upheld

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

**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, Vacuum-Assisted Closure Wound-Healing.

**Decision rationale:** The requested wound care 3 x 4 weeks is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker is still using a wound face to assist with wound healing that does meet wound care supervision. However, Official Disability Guidelines consider this treatment modality to be investigational as there is little scientific evidence to support a wound care vacuum to assist with wound healing to a shoulder injury. Therefore, close monitoring would be required. The request as it is submitted does not allow for continual monitoring to assess the appropriateness of ongoing care. As such, the requested wound care 3 x 4 weeks is not medically necessary or appropriate.

**CHIROPRACTIC CARE 5 X 4 WEEKS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS, 20009, Page 57: Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy And Manipulation Page(s): 58.

**Decision rationale:** The requested chiropractic care 5 x 4 weeks is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has had extensive chiropractic care. However, the clinical documentation does indicate that the injured worker has continued extensive injuries that would require ongoing treatment. However, California Medical Treatment Utilization Schedule recommends ongoing treatment be based on documentation of functional benefit. The clinical documentation indicates the injured worker continues to have severe deficits with very little improvement with this treatment modality. Therefore, continued care would not be supported. Additionally, the requested 20 weeks does not provide for timely reassessment or re-evaluation of this treatment modality. As such, the requested chiropractic care 5 x 4 weeks is not medically necessary or appropriate.

**HOT/COLD MACHINE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross Guidelines

**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:** The requested hot/cold machine is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not specifically address this request. Official Disability Guidelines do not recommend continuous-flow cryotherapy in the absence of surgical intervention. It is documented that the effect on acute injuries has not fully be evaluated and is not supported by scientific evidence. Therefore, the use of a hot/cold machine is not supported. Additionally, the request as it is submitted does not clearly identify if this request is for rental or purchase. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested hot/cold machine is not medically necessary or appropriate.