

Case Number:	CM13-0061047		
Date Assigned:	12/30/2013	Date of Injury:	09/03/2013
Decision Date:	05/22/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/04/2013

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 Physical Medicine and Rehabilitation and is licensed to practice in California. 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:

According to the records made available for review, this is a 57-year-old male with a 9/3/13 date of injury. At the time (11/26/13) of the Decision for pre-operative medical clearance/labs (CBC, CMP, PT, PTT, UA)/chest x-ray/EKG and cold therapy unit (rental or purchase), there is documentation of subjective (left shoulder pain when reaching behind the back and upward with popping and crunching) and objective (not specified) findings, imaging findings (X-rays of the left shoulder (9/3/13) report revealed calcific tendinosis), current diagnoses (left shoulder rotator cuff tear with calcific component, impingement, acromioclavicular degenerative joint disease, and component of posterior-inferior labral tear), and treatment to date (activity modification). In addition, 11/26/13 UR Determination identifies certification of left shoulder arthroscopy. Regarding the requested cold therapy unit (rental or purchase), there is no documentation of the intended duration of therapy (for up to 7 days, including home use) of the requested cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRE-OPERATIVE MEDICAL CLEARANCE/LABS (CBC,CMP,PT,PTT,UA)/ CHEST X-RAY/EKG: Overturned

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) Low Back Chapter, Preoperative Lab Testing Section.

Decision rationale: The California MTUS Guidelines does not address this issue. The Official Disability Guidelines (ODG) identifies that preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, and urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. Within the medical information available for review, there is documentation of diagnoses of left shoulder rotator cuff tear with calcific component, impingement, acromioclavicular degenerative joint disease, and component of posterior-inferior labral tear. In addition, there is documentation of a pending left shoulder surgery that is authorized/certified. Therefore, based on guidelines and a review of the evidence, the request for pre-operative medical clearance/labs (CBC, CMP, PT, PTT, UA)/chest x-ray/EKG is medically necessary.

COLD THERAPY UNIT (RENTAL OR PURCHASE): 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, Continuous Flow Cryotherapy Section.

Decision rationale: The California MTUS does not address this issue. The Official Disability Guidelines (ODG) identifies continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use. Within the medical information available for review, there is documentation of diagnoses of left shoulder rotator cuff tear with calcific component, impingement, acromioclavicular degenerative joint disease, and component of posterior-inferior labral tear. In addition, there is documentation of a pending left shoulder surgery that is authorized/certified and a request for post-operative cold therapy unit. However, there is no documentation of the intended duration of therapy with the requested cold therapy unit. Therefore, based on guidelines and a review of the evidence, the request for cold therapy unit (rental or purchase) is not medically necessary.