

Case Number:	CM14-0014618		
Date Assigned:	02/28/2014	Date of Injury:	05/04/2013
Decision Date:	07/03/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/05/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery, 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:

39 year old claimant with reported industrial injury 5/4/13 after altercation with inmate working as a probation officer. Exam note from 1/13/14 demonstrates complaint of right shoulder pain. Report notes right hand and finger numbness and tingling despite physical therapy and acupuncture. Right shoulder MRI 6/15/13 demonstrates infraspinatus tear. EMG/NCV testing from 9/27/13 demonstrates cubital and carpal tunnel syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

COLD THERAPY UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder Chapter, Continuous Flow Cryotherapy.

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: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case the request is for unspecified

amount of cryotherapy postoperatively. As this request is non specific as it relates to the guideline the determination is for non-certification.

REFERRAL TO HAND/ELBOW/WRIST SPECIALIST FOR EVALUATION AND TREATMENT FOR RIGHT ELBOW AND HAND/WRIST: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7, Independent Medical Examinations and Consultations.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127.

Decision rationale: Per the CA MTUS ACOEM 2004, Chapter 7, page 127 states the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial facts are present, or when the plan or course of care may benefit from additional expertise. In this case there are multiple diagnoses in this patient and lack of clear rationale in the records from 1/13/14 to warrant referral. Therefore the determination is non-certification.

PREOPERATIVE MEDICAL CLEARANCE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA 2007 Guidelines on perioperative Cardiovascular Evaluation and Care for Non-cardiac Surgery.

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.

Decision rationale: CA MTUS/ACOEM and ODG Shoulder chapter are silent on the issue of preoperative testing. An alternative chapter in ODG, Low back is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. In this case the patient is a healthy 39 year old without comorbidities or physical examination findings concerning for preoperative testing prior to the proposed surgical procedure. Therefore the determination is for non-certification.

ELECTRICAL STIMULATION (E-STIM): Upheld

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

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, Electrical Stimulation.

Decision rationale: CA MTUS/ACOEM is silent on the issue of electrical stimulation. According to ODG criteria it is not recommended for the shoulder. Therefore the determination is for non-certification.

CONTINUOUS PASSIVE MOTION (CPM) UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder Chapter, Continuous Passive Motion (CPM).

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

Decision rationale: CA MTUS/ACOEM guidelines is silent on the issue of CPM machine. According to the Official Disability Guidelines, Shoulder Chapter, Continuous passive motion (CPM), CPM is recommended for patients with adhesive capsulitis but not with patients with rotator cuff pathology primarily. As there is no evidence preoperatively of adhesive capsulitis in the cited records, the determination is for non-certification.