

Case Number:	CM14-0132458		
Date Assigned:	08/22/2014	Date of Injury:	08/15/2010
Decision Date:	10/28/2014	UR Denial Date:	08/12/2014
Priority:	Standard	Application Received:	08/19/2014

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 Texas. 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 65-year-old female who reported an injury on 08/15/2010. The mechanism of injury was reportedly repetitive work. Her diagnoses were herniated nucleus pulposus at L4-5 and L5-S1 with spondylosis at L5-S1, status post L1 and L2 transverse process fractures, status post left shoulder arthroscopic rotator cuff repair, status post right shoulder rotator cuff debridement with biceps tenotomy, right lower extremity radiculopathy, anxiety, depression, and insomnia secondary to industrial injury and pain. Her previous treatments included medications, injections, bracing, and rest. The diagnostics included x-rays of the right shoulder and humerus which showed severe rotator cuff arthropathy, and x-rays of the left shoulder and humerus which showed mild degenerative changes. Prior surgeries included a left shoulder arthroscopic rotator cuff repair on 07/27/2011 and a right shoulder rotator cuff debridement on 12/21/2011. On 07/24/2014 the injured worker complained of bilateral shoulder pain. She reported that she could only lift the right arm a few degrees due to marked pain and weakness, and complained of pain in the right shoulder at rest. The physical examination revealed marked tenderness to both shoulders. The supraspinatus motor strength was 4+/5 bilaterally and sensation was intact. Also, the 2 point discrimination was 6 mm in all digits, impingement tests 1 and 2 were positive, and the drop arm test on the right shoulder was positive as well. Her medications were noted as Ultracet, Flexeril, Medrox patches, flurbiprofen 20% cream, and ketoprofen 20%/ketamine 10% cream. The treatment plan was for postoperative DME (undetermined), cold therapy unit purchase, and a CPM machine times 21 day rental. The rationale for the request and the Request for Authorization form were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Postoperative DME (undetermined): 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), Knee & leg, Durable medical equipment (DME)

Decision rationale: Based on the clinical information submitted for review, the request for Postoperative DME (undetermined) is not medically necessary. As stated in the Official Disability Guidelines, durable medical equipment is defined as equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in the patient's home. It is generally recommended if there is a medical necessity, and if the device or system meets Medicare's definition of durable medical equipment. The injured worker complained of bilateral shoulder pain with the right greater than the left, and reportedly was only able to lift the right arm a few degrees secondary to marked pain and weakness. Although postoperative durable medical equipment may be warranted per the guidelines, there is insufficient detail as to what equipment is being requested. As such, the request for Postoperative DME (undetermined) is not medically necessary.

Cold therapy unit - purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: The 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, Continuous-flow cryotherapy

Decision rationale: Based on the clinical information submitted for review, the request for a Cold therapy unit - purchase is not medically necessary. As stated in the Official Disability Guidelines, continuous flow cryotherapy is recommended as an option after surgery, and may be used up to 7 days including home use. Continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The injured worker complained of bilateral shoulder pain, with the right being greater than the left. The guidelines indicate that postoperative use of continuous flow cryotherapy may be up to 7 days in the home; however, the request is for a purchase of the unit. As such, the request for a Cold therapy unit - purchase is not medically necessary.

Continuous passive motion (CPM) machine times 21 day rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines:CPM only in adhesive capsulitis conditions.

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 (CPM)

Decision rationale: Based on the clinical information submitted for review, the request for a CPM machine times 21 day rental is not medically necessary. As stated in the Official Disability Guidelines, continuous passive motion is not recommended for shoulder rotator cuff problems, but is recommended as an option for adhesive capsulitis. The injured worker complained of bilateral shoulder pain, with pain being greater in the right than the left shoulder. It was noted that the physician was requesting authorization to proceed with a reverse total shoulder arthroplasty. The guidelines indicate that continuous passive motion is only recommended for adhesive capsulitis. The clinical information submitted for review did not include a diagnosis of adhesive capsulitis. As such, the request for a CPM machine times 21 day rental is not medically necessary.