

Case Number:	CM14-0168443		
Date Assigned:	10/16/2014	Date of Injury:	10/27/2012
Decision Date:	11/25/2014	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/13/2014

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 Occupational Medicine 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 32-year-old male with a 10/27/12 date of injury. At the time (8/15/14) of request for authorization for Deep Vein Thrombosis (DVT) Unit, Continuous Passive Motion (CPM) Machine, and Motorized Cold Therapy Unit, there is documentation of subjective (right shoulder pain) and objective (decreased bilateral shoulder range of motion and positive bilateral impingement sign) findings, current diagnoses (cervical spine sprain and bilateral shoulder impingement syndrome with anterior labral tear), and treatment to date (medications). Medical report identifies the request for DVT unit, CPM machine, and Motorized cold therapy unit for post-surgical (right shoulder arthroscopy with subacromial decompression and debridement) use. There is no documentation of a pending surgery that has been authorized /certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

DVT (Deep Vein Thrombosis) Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability 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, Subacromial Decompression and Manipulation, Anesthesia and Deep Vein Thrombosis (DVT)

American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), page(s) 209-211

Decision rationale: MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, AP, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of cervical spine sprain and bilateral shoulder impingement syndrome with anterior labral tear. In addition, there is documentation of a request for DVT unit for post-surgical (right shoulder arthroscopy with subacromial decompression and debridement) use. However, there is no documentation of a pending surgery that has been authorized /certified. Therefore, based on guidelines and a review of the evidence, the request for DVT Unit is not medically necessary.

Continuous Passive Motion (CPM) Machine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability 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, Subacromial Decompression and Manipulation, Anesthesia and Continuous Passive Motion (CPM) American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), page(s) 209-211

Decision rationale: MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, AP, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of cervical spine sprain

and bilateral shoulder impingement syndrome with anterior labral tear. In addition, there is documentation of a request for CPM machine for post-surgical (right shoulder arthroscopy with subacromial decompression and debridement) use. However, there is no documentation of a pending surgery that has been authorized /certified. Therefore, based on guidelines and a review of the evidence, the request for Continuous Passive Motion (CPM) Machine is not medically necessary.

Motorized Cold Therapy Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability 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, Subacromial Decompression and Manipulation, Anesthesia and Continuous-flow Cryotherapy American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), page(s) 209-211

Decision rationale: MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, AP, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of cervical spine sprain and bilateral shoulder impingement syndrome with anterior labral tear. In addition, there is documentation of a request for Motorized cold therapy unit for post-surgical (right shoulder arthroscopy with subacromial decompression and debridement) use. However, there is no documentation of a pending surgery that has been authorized /certified. Therefore, based on guidelines and a review of the evidence, the request for Motorized Cold Therapy Unit is not medically necessary.