

Case Number:	CM14-0079277		
Date Assigned:	09/10/2014	Date of Injury:	12/16/2009
Decision Date:	10/30/2014	UR Denial Date:	05/13/2014
Priority:	Standard	Application Received:	05/29/2014

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 59-year-old male with a 12/16/09 date of injury and status post left shoulder diagnostic arthroscopy, extensive synovectomy, chondroplasty of the glenoid, left shoulder arthrotomy, open subacromial decompression with resection of the CA ligament, and repair of the rotator cuff tear on 4/4/14. At the time (3/18/14) of the request for authorization for [REDACTED] DVT prevention system for home use up to 21 days, Prosling with abduction pillow purchase, non-programmable pain pump purchase, [REDACTED] cold therapy recovery system wrap with wrap for home use for up to 21 days, and Physical Therapy 3 X Per Week x 6 Weeks Left Shoulder, there is documentation of subjective (awaiting authorization for left shoulder surgery) and objective (discomfort is noted on elevation of left upper extremity against gravity at approximately 95 degrees) findings, current diagnoses (left shoulder tendinitis/bursitis), and treatment to date (shoulder surgery).

IMR ISSUES, DECISIONS AND RATIONALES

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

[REDACTED] DVT prevention system for home use up to 21 days: 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, compression garments

Decision rationale: MTUS does not address the issue. ODG states compression garments are not generally recommended in the shoulder. Deep venous thrombosis and pulmonary embolism events are common complications following lower-extremity orthopedic surgery, but they are rare following upper-extremity surgery, especially shoulder arthroscopy. It is still recommended to perform a thorough preoperative workup to uncover possible risk factors for deep venous thrombosis/ pulmonary embolism despite the rare occurrence of developing a pulmonary embolism following shoulder surgery. Therefore, based on guidelines and a review of the evidence, the request for [REDACTED] DVT prevention system for home use up to 21 days is not medically necessary.

Prosling with Abduction Pillow Purchase: 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) Shoulder, Postoperative abduction pillow sling

Decision rationale: MTUS does not address this issue. ODG identifies documentation of a diagnosis/condition for which postoperative abduction pillow sling is indicated (such as open repair of large and massive rotator cuff tears) as criteria necessary to support the medical necessity of postoperative abduction pillow sling. Within the medical information available for review, there is documentation of diagnoses of left shoulder tendinitis/bursitis. In addition, there is documentation that the patient underwent left shoulder diagnostic arthroscopy, extensive synovectomy, chondroplasty of the glenoid, left shoulder arthrotomy, open subacromial decompression with resection of the CA ligament, and repair of the rotator cuff tear on 4/4/14. Therefore, based on guidelines and a review of the evidence, the request for Prosling with abduction pillow purchase is medically necessary.

Non-Programmable Pain Pump 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, Postoperative pain pump

Decision rationale: MTUS does not address this issue. ODG identifies that post-operative pain pump is not recommended and that there is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using

oral, intramuscular or intravenous measure. Therefore, based on guidelines and a review of the evidence, the request for non-programmable pain pump purchase is not medically necessary.

■■■■■ cold therapy recovery system with wrap for home use for up to 21 days: 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, Continuous-flow cryotherapy

Decision rationale: MTUS does not address the issue. ODG supports continuous-flow cryotherapy 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 tendinitis/bursitis. In addition, there is documentation that the patient underwent left shoulder diagnostic arthroscopy, extensive synovectomy, chondroplasty of the glenoid, left shoulder arthrotomy, open subacromial decompression with resection of the CA ligament, and repair of the rotator cuff tear on 4/4/14. However, the requested ■■■■■ cold therapy recovery system wrap with wrap for home use for up to 21 days exceeds guidelines. Therefore, based on guidelines and a review of the evidence, the request for ■■■■■ cold therapy recovery system wrap with wrap for home use for up to 21 days is not medically necessary.

Physical Therapy 3 times Per Week for 6 Weeks Left Shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: MTUS Postsurgical Treatment Guidelines identifies up to 24 visits of post-operative physical therapy over 14 weeks and post-surgical physical medicine treatment period of up to 6 months. In addition, MTUS postsurgical treatment Guidelines identifies that the initial course of physical therapy following surgery is 1/2 the number of sessions recommended for the general course of therapy for the specified surgery. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of left shoulder tendinitis/bursitis. In addition, there is documentation of status post left shoulder diagnostic arthroscopy, extensive synovectomy, chondroplasty of the glenoid, left shoulder arthrotomy, open subacromial decompression with resection of the CA ligament, and repair of the rotator cuff tear on 4/4/14. However, the requested Physical Therapy 3 X Per Week x 6 Weeks Left Shoulder is more than 1/2 the number of sessions recommended for the general course of therapy for the specified

surgery. Therefore, based on guidelines and a review of the evidence, the request for Physical Therapy 3 X Per Week x 6 Weeks Left Shoulder is not medically necessary.