

Case Number:	CM14-0081042		
Date Assigned:	08/06/2014	Date of Injury:	05/29/2012
Decision Date:	09/22/2014	UR Denial Date:	05/16/2014
Priority:	Standard	Application Received:	06/02/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 38-year-old male who reported an injury on 05/29/2012. The mechanism of injury was not specifically stated. The current diagnosis is right shoulder internal derangement with osteoarthritis. Previous conservative treatment is noted to include home exercise, physical therapy, and medications. The injured worker is noted to have undergone electrodiagnostic studies in 03/2014, which indicated bilateral cubital tunnel syndrome. The injured worker was evaluated on 01/28/2014 with complaints of right shoulder and elbow pain with numbness of the hand. The physical examination revealed tenderness at the AC joint and subacromial space, limited range of motion, positive impingement sign, positive Tinel's testing at the right wrist and elbow, and weakness in the right shoulder. Treatment recommendations included a right shoulder arthroscopic subacromial decompression and possible rotator cuff repair. An operative report was then submitted on 02/06/2014, indicating that the injured worker underwent a right shoulder arthroscopy. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Q-TECH DVT Prevention System 35 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 Shoulder - Venous Thrombosis.

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, Venous Thrombosis.

Decision rationale: The Official Disability Guidelines recommend monitoring the risk of perioperative thromboembolic complications in both the acute and subacute postoperative periods for possible treatment, and identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures such as consideration for anticoagulation therapy. There is no indication that this injured worker was at high risk of developing a deep vein thrombosis following surgery. There was also no mention of a contraindication to oral anticoagulation therapy as opposed to a motorized unit. Therefore, the medical necessity has not been established. As such, the request is not medically appropriate.

Shoulder Continuous passive Motion unit with pad 30 days: Upheld

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

Decision rationale: The Official Disability Guidelines recommend continuous passive motion as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Therefore, the injured worker does not currently meet criteria for the requested durable medical equipment. As such, the request is not medically appropriate.

Pro-sling with Abduction pillow for Purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline Shoulder Post operative abduction pillow sling.

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, Postoperative abduction pillow sling.

Decision rationale: The Official Disability Guidelines recommend postoperative abduction pillow sling as an option following an open repair of a large and massive rotator cuff tear. Abduction pillows are not recommended for arthroscopic repairs. Therefore, the request is not medically appropriate.

X-Force Stimulator unit plus 3 months supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: California MTUS Guidelines recommend TENS therapy as a treatment option for acute postoperative pain in the first 30 days following surgery. A form fitting TENS device is only considered medically necessary when there is documentation of a large area that requires stimulation that a conventional system cannot accommodate. There is no mention of a contraindication to a traditional system. The current request for a 3 month rental also exceeds Guideline recommendations. As such, the request is not medically appropriate.

Conductive Garment 30 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS post operative Page(s): 116-117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: California MTUS Guidelines recommend TENS therapy as a treatment option for acute postoperative pain in the first 30 days following surgery. A form fitting TENS device is only considered medically necessary when there is documentation of a large area that requires stimulation that a conventional system cannot accommodate. There is no mention of a contraindication to a traditional system. The current request for a 3 month rental also exceeds Guideline recommendations. As such, the request is not medically appropriate.

Trial Q-tech cold therapy recovery system with Wrap 35 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines -Shoulder - 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: The Official Disability Guidelines recommend continuous flow cryotherapy as an option following surgery, for up to 7 days. The current request for a 35 day rental exceeds Guideline recommendations. Therefore, the request is not medically appropriate.