

Case Number:	CM14-0087969		
Date Assigned:	07/23/2014	Date of Injury:	02/10/2010
Decision Date:	08/27/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/12/2014

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:

The injured worker is a 41-year-old female who reported an injury on 02/19/2010 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to her right shoulder. The injured worker's treatment history included medications, physical therapy, and corticosteroid injections. The injured worker was evaluated on 05/05/2014 with documented pain complaints of the right shoulder rated at 6/10 to 10/10. Physical findings included restricted range of motion of the right shoulder with severe tenderness to the supraspinatus and moderate tenderness to the greater tuberosity of the right shoulder. The injured worker had positive subacromial crepitus and 4/5 motor strength of the right upper extremity. The injured worker had a positive acromioclavicular joint compression test, impingement test, and a negative Speed's test and O'Brien's test on the right side. It was noted that an ultrasound study of the right shoulder revealed acromioclavicular degenerative joint disease. A request was made for surgical intervention with postoperative durable medical equipment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-operative medical clearance with CBC, CMP, and UA: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Preoperative Lab Testing.

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 Chapter, Pre-Operative Lab Testing (general).

Decision rationale: The California Medical Treatment Utilization Schedule does not specifically address this request. The Official Disability Guidelines recommend preoperative testing for injured workers who have co-morbidities or complicated diagnoses that would contribute to intraoperative or postoperative complications. The clinical documentation submitted for review indicates that the injured worker is a young female possible undergoing ambulatory surgery with no documentation of complicating risk factors. Therefore, preoperative medical clearance would not be supported in this clinical situation. Furthermore, there is no documentation that the injured worker has been authorized for surgical intervention or that surgical intervention has been scheduled. As such, the requested preoperative medical clearance with CBC, CMP, and UA is not medically necessary or appropriate.

Home continuous passive motion (CPM) for a period of forty-five (45) 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 Chapter.

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 (CPM).

Decision rationale: The California Medical Treatment Utilization Schedule does not address this request. The Official Disability Guidelines do not recommend home continuous passive motion machines for rotator cuff injuries. This type of equipment is generally recommended for adhesive capsulitis. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested home continuous passive motion machine for a period of 45 days is not medically necessary or appropriate.

Surgi-Stim unit, ninety (90) days: 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 TENS and NMES Unit, page(s) 116 and 121 Page(s): 116 and 121.

Decision rationale: The California Medical Treatment Utilization Schedule recommends up to 30 days use of a TENS unit in the postsurgical treatment of a patient. However, the requested equipment also contains a neuromuscular electrical stimulation device. This type of equipment is generally only recommended by the California Medical Treatment Utilization Schedule for

patients who are stroke victims undergoing rehabilitation. The clinical documentation does not support the need for this type of stimulation. Additionally, as the request exceeds the 30-day trial recommendation without any exceptional factors to support extended treatment, the request would not be indicated in this clinical situation. As such, the requested Surgi-Stim unit for 90 days is not medically necessary or appropriate.

Coolcare 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, Shoulder Chapter.

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 California Medical Treatment Utilization Schedule does not address this request. The Official Disability Guidelines recommend up to a 7-day rental of a continuous flow cryotherapy unit in the postsurgical management following shoulder surgery. The request as it is submitted does not clearly identify whether this unit is for rental or purchase. Additionally, duration of treatment is not specified within the request. Furthermore, there is no documentation that the injured worker has been authorized for surgical intervention or that surgical intervention is scheduled. As such, the requested Cool care cold therapy unit is not medically necessary or appropriate.