

Case Number:	CM14-0089927		
Date Assigned:	07/23/2014	Date of Injury:	03/25/2012
Decision Date:	09/26/2014	UR Denial Date:	05/19/2014
Priority:	Standard	Application Received:	06/13/2014

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 Internal Medicine and is licensed to practice in North Carolina, California, Colorado, and Kentucky. 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 46 year old male who reported an injury to his left shoulder. The utilization review dated 05/19/14 indicates the injured worker having undergone a diagnostic arthroscopy with debridement, subacromial decompression. The request for a cold therapy recovery system, DVT prevention system, pain pump, abduction pillow all resulted in denials as insufficient information had been submitted confirming the need for a 21 day use of the cold therapy and DVT system. Additionally, no information had been submitted regarding the need for a pain pump. Additionally, no information had been submitted regarding the injured worker's recovery from a rotator cuff surgery indicating the need for an abduction sling pillow. The clinical note dated 06/30/14 indicates the injured worker reporting improvement following a second left shoulder surgery. The note indicates the injured worker able to demonstrate 95 degrees of elevation. The clinical note dated 06/30/14 indicates the injured worker utilizing Norco for pain relief. The clinical note dated 03/31/14 indicates the injured worker able to demonstrate 4/5 strength throughout the left deltoid. The operative report dated 03/21/14 indicates the injured worker undergoing subacromial decompression at the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro DOS 03/21/14 Q-Tech Cold Therapy Recovery System with Wrap x 21 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter- Cold Compression Therapy.

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 Cryo-Therapy.

Decision rationale: The request for retro Q-tech cold therapy recovery system with wrap for 21 days is not medically necessary. The documentation indicates the injured worker undergoing subacromial decompression at the left shoulder. A cold therapy unit is indicated for up to 7 days following surgery of this nature. The request for 21 days use of a cold therapy system exceeds recommendations. Therefore, this request is not indicated as medically necessary.

Retro DOS 03/21/14 Q-Tech DVT Prevention System x 21 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 (ODG) Shoulder Chapter, Venous Thrombosis, Compression Garments.

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 request for DVT prevention system for 21 days is not medically necessary. No information was submitted regarding the injured worker's confirmation regarding a deep vein thrombosis. No Doppler studies were submitted. No information was submitted regarding the injured worker's cardiac, pulmonary or respiratory issues. Therefore, this request is not indicated as medically necessary.

Retro DOS 03/21/14 Non- Programmable Pain Pump 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 (ODG) Shoulder Chapter-Postoperative Pain Pump; <http://www.ncbi.nlm.nih.gov/pubmed/19501296>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Implantable drug-delivery systems (IDDSs).

Decision rationale: The request for non-programmable pain pump purchase is not medically necessary. No information was submitted regarding the need for a pain pump in the postoperative setting. Therefore, this request is not indicated.

Retro DOS 03/21/14 Pro-Sling with Abduction Pillow Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter- Postoperative 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: A Pro-Sling abduction pillow is indicated following a rotator cuff surgery. No information was submitted confirming the injured worker having undergone a rotator cuff procedure. Given this, the request is not indicated as medically necessary.