

Case Number:	CM14-0187104		
Date Assigned:	11/17/2014	Date of Injury:	06/13/2012
Decision Date:	01/05/2015	UR Denial Date:	10/17/2014
Priority:	Standard	Application Received:	11/10/2014

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:

According to the records made available for review, this is a 62-year-old male with a 6/13/12 date of injury. At the time (10/9/14) of request for authorization for Pre-Operative Medical Clearance to Include CBC, CMP, PT/PTT, UA, EKG and Chest X-Ray; Cold Therapy Unit Purchase; and Pain Pump Purchase, there is documentation of subjective (right shoulder pain and weakness) and objective (limited range of motion of the right shoulder, severe weakness to abduction and forward flexion, and positive impingement sign) findings, current diagnoses (rotator cuff arthropathy of the right shoulder), and treatment to date (physical therapy and medications). Medical reports identify a pending total shoulder arthroplasty surgery that has been certified/authorized. Regarding Cold Therapy Unit Purchase, there is no documentation that the requested cold therapy unit will be used postoperatively for up to 7 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-Operative Medical Clearance to Include CBC, CMP, PT/PTT, UA, EKG and Chest X-Ray: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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, Preoperative lab testing

Decision rationale: MTUS does not address this issue. ODG identifies that preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. Within the medical information available for review, there is documentation of a diagnosis of rotator cuff arthropathy of the right shoulder. In addition, there is documentation of a pending total shoulder arthroplasty surgery that has been certified/authorized. However, there is no documentation of a rationale for the medical necessity of the requested UA, PT/PTT, and Chest X-ray. Therefore, based on guidelines and a review of the evidence, the request for Pre-Operative Medical Clearance to Include CBC, CMP, PT/PTT, UA, EKG and Chest X-Ray is not medically necessary.

Cold Therapy Unit Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment 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, Polar care (cold therapy unit)

Decision rationale: MTUS does not address this issue. ODG states that continuous-flow cryotherapy is recommended postoperatively for up to 7 days, including home use. Within the medical information available for review, there is documentation of a diagnosis of rotator cuff arthropathy of the right shoulder. In addition, there is documentation of a pending total shoulder arthroplasty surgery that has been certified/authorized. However, the requested cold therapy unit purchase exceeds guidelines (up to 7 days, including home use). Therefore, based on guidelines and a review of the evidence, the request for Cold Therapy Unit Purchase is not medically necessary.

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)

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 Pain Pump Purchase is not medically necessary.