

Case Number:	CM14-0187723		
Date Assigned:	12/04/2014	Date of Injury:	02/27/2004
Decision Date:	01/23/2015	UR Denial Date:	10/20/2014
Priority:	Standard	Application Received:	11/11/2014

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 claimant is a 60 year old female with an industrial injury dated 02/27/04. The patient is status post an anterior cervical discectomy and fusion at C4-5, and a right shoulder subacromial decompression; along with a left small finger fracture. Exam note 09/04/14 states the patient returns with low back pain. The patient explains that the pain is radiating down to the right buttocks with numbness and tingling. The patient rates the pain a 8/10. The patient explains that the pain is increased with prolonged walking and standing. The patient also complains of right shoulder pain in which she rates a 10/10. Conservative treatments have included physical therapy, and injections all resulting in little pain relief. Current medications include Motrin. Upon physical exam, there was evidence of tenderness over the anterior capsule and AC joint regions on the right shoulder. Range of motion is noted as a flexion of 100' on the right, 40' extension, 90' abduction, 65' internal rotation, and 85' external rotation. The patient demonstrated pain with the range of motion test and had a 4/5 weakness of the right shoulder. The patient is noted to have a positive impingement sign test and apprehension test for the right shoulder. There was also evidence of tenderness surrounding the lumbar spine on the right side and the paraspinal musculature. Diagnosis is noted as a sprain/strain of the right and left hip, along with the lumbar spine. Treatment includes a right shoulder arthroscopy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: CPM machine/kit 4 week rental (rental or 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 Treatment in Workers' Compensation, Shoulder Procedure Summary (updated 8/27/14), 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 (CPM)

Decision rationale: CA MTUS/ACOEM guidelines are silent on the issue of CPM machine. According to the Official Disability Guidelines, Shoulder Chapter, Continuous passive motion (CPM), CPM is recommended for patients with adhesive capsulitis but not with patients with rotator cuff pathology primarily. With regards to adhesive capsulitis, it is recommended for 4 weeks. There is no evidence preoperatively of adhesive capsulitis in the cited records. Therefore, this request is not medically necessary.

Associated surgical service: Cold therapy unit 4 week rental (rental or purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 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) Continuous flow cryotherapy

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case, the request of 4 weeks exceeds the recommended duration of the cryotherapy unit. Therefore, this request is not medically necessary.

Associated surgical service: VenaPro pneumatic compression device and supplies (rental or 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 Treatment in Workers' Compensation , Shoulder Procedure Summary (updated 8/27/14)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Compression garments

Decision rationale: CA MTUS/ACOEM is silent on compression garments for DVT (deep vein thrombosis) prophylaxis. According to ODG, Shoulder section, Compression garments, "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. Mechanical or chemical prophylaxis should be administered for patients with identified coagulopathic risk factors." In this case, there is no evidence of risk factor for DVT in the clinical records from 9/4/14. Therefore, this request is not medically necessary.

Pre-op medical clearance/history and physical/EKG/chest x-ray/laboratory work-up:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Compensation, Low Back Procedure Summary (updated 8/22/14), Preoperative testing

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<http://www.brighamandwomens.org/gms/Medical/preopprotocols.aspx>

Decision rationale: CA MTUS and ODG are silent on the issue of preoperative clearance. Alternative guidelines were therefore referenced. The listed medical evidence states that patients greater than age 40 require a CBC; males require an ECG if greater than 40 and female is greater than age 50; this is for any type of surgery. In this case, the claimant is 60 years old and does not have any evidence in the cited records from 9/4/14 of significant medical comorbidities to support a need for preoperative clearance including history/physical exam, EKG, CXR, and labs. Therefore, this request is not medically necessary.