

Case Number:	CM15-0016235		
Date Assigned:	02/04/2015	Date of Injury:	09/27/2012
Decision Date:	04/17/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	01/28/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: North Carolina
 Certification(s)/Specialty: Family Practice

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 48-year-old male, who sustained an industrial injury on September 27, 2012. He has reported increased shoulder pain while scraping large paint tanks. The diagnoses have included rotator cuff sprain/strain. Treatment to date has included diagnostic studies, surgery, physical therapy, medications and injections. Currently, the injured worker complains of right shoulder pain and weakness. Symptoms include pain with activity, pain with range of motion and popping. Range of motion of the right shoulder included active forward flexion of 0-150 degrees, active extension 0-30 degrees, active internal rotation 0-30 degrees, active external rotation 0-30 degrees and active abduction of 1-150 degrees. On January 27, 2015, Utilization Review non-certified Toradol #20, CPM x 14 days and purchase of Polar Care, noting the Official Disability Guidelines. On January 28, 2015, the injured worker submitted an application for Independent Medical Review for review of Toradol #20, CPM x 14 days and purchase of Polar Care.

IMR ISSUES, DECISIONS AND RATIONALES

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

Toradol #20: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Ketorolac.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 68.

Decision rationale: The California chronic pain medical treatment guidelines section on NSAID therapy states: Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Ketorolac (Toradol, generic available): 10 mg. [Boxed Warning]: This medication is not indicated for minor or chronic painful conditions. This medication is recommended for the shortest period of time and at the lowest dose possible. The shortest time period is not defined in the California MTUS. The requested medication is within the maximum dosing guidelines per the California MTUS and is being used post surgery. Therefore, the request is certified.

CPM (Continuous Passive Motion Machines) x 14 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: Adhesive capsulitis: CPM treatment; Continuous flow Cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, continuous passive motion.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. Per the Official Disability Guidelines section on CPM, it may offer beneficial results compared to PT alone in the short-term rehabilitation following total knee arthroplasty. Criteria for the use of CPM devices included: May be considered medically necessary for up to 21 days postoperatively for the following surgical procedures: 1. Total knee arthroplasty. 2. Anterior cruciate ligament reconstruction. 3. Open reduction and internal fixation of the tibial plateau or distal femur fractures involving the knee joint. The patient is post shoulder surgery, which is not recommended per the ODG and is thus not certified.

Purchase of Polar Care: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Continuous Flow Cryotherapy; Cold Therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, cryotherapy.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. The ACOEM does recommend the at home local application of cold packs the first few days after injury and thereafter the application of heat packs. The Official Disability Guidelines section on cryotherapy states: Recommended as an option after surgery but not for nonsurgical treatment. The patient is post shoulder surgery therefore the therapy is indicated, however the permanent purchase of a unit versus rental of the equipment is not necessary and the request is not certified.