

Case Number:	CM15-0189180		
Date Assigned:	10/01/2015	Date of Injury:	04/10/2013
Decision Date:	11/09/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/25/2015

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: Arizona, California

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 55 year old female, who sustained an industrial-work injury on 4-10-13. A review of the medical records indicates that the injured worker is undergoing treatment for left shoulder pain and left shoulder impingement syndrome. Medical records dated (4-14-15 to 8-11-15) indicate that the injured worker complains of persistent left shoulder pain and neck pain that radiates to the left arm. The pain is rated 7 out of 10 on the pain scale and started 2 years ago with minimal improvement despite physical therapy and anti-inflammatories. The pain is worse with activities and improves with medication. Per the treating physician, report dated 8-11-15 the work status is modified with restrictions. The physical exam dated from (4-14-15 to 8-11-15) reveals decreased range of motion and decreased strength in the left upper extremity secondary to pain. There is tenderness to palpation of the left shoulder, and spasms of the bilateral upper trapezius muscles. There is positive Neer and apprehension sign in the left shoulder. The physician indicates that surgical intervention is recommended. Treatment to date has included pain medication including Gabapentin and Ibuprofen, physical therapy, injections, left shoulder arthroscopy 8-20-15, subacromial injection with temporary relief, and other modalities. Magnetic resonance imaging (MRI) of the left shoulder dated 9-27-13 reveals tendinosis, and displacement of the humeral head. The request for authorization date was 8-20-15 and requested services included intermittent pneumatic compression therapy device for 4 week rental, bilateral pneumatic appliance times 2 for purchase and cooling system for 4 week rental. The original Utilization review dated 8-28-15 non-certified the request for intermittent pneumatic

compression therapy device for 4 week rental, bilateral pneumatic appliance times 2 for purchase and cooling system for 4 week rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

Intermittent pneumatic compression therapy device for 4 week rental: 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 chapter and pg 10.

Decision rationale: According to the guidelines, compressions is not recommended after shoulder surgery. Risk of DVT is low. In this case, there was no mention of hypercoagulable state or edema that would require a month of compression after surgery. The request for the compression therapy for 4 weeks is not medically necessary.

Bilateral pneumatic appliance times 2 for 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 chapter and pg 10.

Decision rationale: According to the guidelines, compressions are not recommended after shoulder surgery. Risk of DVT is low. In this case, there was no mention of hypercoagulable state or edema that would require a month of compression after surgery. Similar to compression therapy, the indefinite use of a pneumatic device for compression for shoulder surgery is not required. The request for the purchase pneumatic appliance is not medically necessary.

Cooling system for 4 week rental: 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 chapter and pg.

Decision rationale: According to the guidelines, cold compression therapy is not recommended for shoulder surgery. Some other body regions are recommended to receive up to 7 days of cold

compression after surgery. In this case, the request for 4 weeks exceeds the guidelines for most surgeries and is not medically necessary after shoulder surgery.