

Case Number:	CM15-0196231		
Date Assigned:	10/09/2015	Date of Injury:	02/13/2014
Decision Date:	11/25/2015	UR Denial Date:	09/28/2015
Priority:	Standard	Application Received:	10/06/2015

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: California, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 49 year old female who sustained a work-related injury on 2-13-14. On 2-24-15 the injured worker had significant left shoulder pain. Her left shoulder range of motion on 2-24-15 included abduction to 120 degrees, forward flexion to 120 degrees, external rotation to 80 degrees and internal rotation to 90 degrees. She has positive impingement signs with Hawkins and Neer testing. On 4-27-15 the injured worker reported left shoulder pain which she rated an 8 on a 10-point scale (same as 3-23-15) She had diffuse left shoulder tenderness. Her medications included Tramadol ER, Naproxen, pantoprazole and cyclobenzaprine 10 mg. On 5-18-15, the injured worker underwent left shoulder arthroscopic subacromial decompression, arthroscopic debridement of partial-thickness rotator cuff tear, arthroscopic partial distal claviclectomy-Mumford procedure, and arthroscopic synovectomy and bursectomy for left shoulder chronic impingement syndrome with partial thickness rotator cuff tear. The injured worker was discharged with a cold therapy unit with pad, Arc Brace 2.0, and DVT EZ-fit VT calf wrap provided to her post-operatively. A request for retrospective Arc Brace 2.0 for date of service 5-18-15, retrospective DVT (deep vein thrombosis) EZ-Fit VT Calf Wrap for date of service 5-18-15 and retrospective Cold Therapy Unit with Pad for date of service 5-18-15 was received on 5-18-15. On 9-28-15, the Utilization Review physician determined retrospective Arc Brace 2.0 for date of service 5-18-15, retrospective DVT (deep vein thrombosis) EZ-Fit VT Calf Wrap for date of service 5-18-15 was not medically necessary and retrospective Cold Therapy Unit with Pad for date of service 5-18-15 was modified to Cold Therapy Unit with Peripheral artery disease to a seven day post-operative use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Arc Brace 2.0 DOS: 5/18/2015: 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) Post-operative abduction pillow sling.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder chapter, Post-operative abduction pillow sling.

Decision rationale: The records indicate the patient was having left shoulder pain and dysfunction following left shoulder arthroscopic surgery on 5/18/15. The current request for consideration is retrospective ARC brace 2.0 DOS: 5/18/15. No medical report was made available for review with date of service 5/18/15 from the primary treating physician. The ODG has this to say about abduction pillow slings: Recommended as an option following open repair of large and massive rotator cuff tears and other shoulder surgeries. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. In this case, the records indicate that the patient had an arthroscopic shoulder surgery and not an open repair. No medical report is available for review which would justify the use of an Arc brace and therefore the request is not medically necessary.

Retrospective DVT (deep vein thrombosis) EZ-Fit VT Calf Wrap DOS: 5/18/2015: 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 (updated 9/8/2015) Online version, Brace.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee and Leg Chapter, DVT unit.

Decision rationale: The records indicate the patient was having left shoulder pain and dysfunction following left shoulder arthroscopic surgery on 5/18/15. The current request for consideration is Retrospective Deep Vein Thrombosis (DVT) EZ-Fit VT Calf wrap DOS: 5/18/15. No attending physician report is available for review. The ODG guidelines recognize DVT risk factor after orthopedic surgery and hospitalization. The attending physician has made a recommendation EZ-Fit VT Calf wrap following his shoulder surgery, but in this case, does not provide any risk factors for perioperative thromboembolic complications. Vasopneumatic compressive devices are medically necessary for those patients who are unable to walk and are bedridden. There is no documentation that the patient will be bedridden. The current request is not supported by the available medical records and is not medically necessary.

Retrospective Cold Therapy Unit with Pad DOS: 5/18/2015: 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 (updated 9/8/2015) Online version Continuous-flow cryotherapy.

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

Decision rationale: The records indicate the patient was having left shoulder pain and dysfunction following left shoulder arthroscopic surgery on 5/18/15. The current request for consideration is Retrospective Cold therapy unit with pad DOS: 5/18/15. No attending physician report is available for review. ODG does recommend continuous flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy (i.e, frostbite) are extremely rare but can be devastating. In this case, the records do indicate the patient had arthroscopic shoulder surgery on 5/18/15. A request for authorization was completed as the attending physician felt that the cold therapy unit would benefit the recovery process. The current request does not specify the number of days that the unit is being prescribed and ODG limits the usage to 7 days. The request is not medically necessary.