

Case Number:	CM15-0197974		
Date Assigned:	10/13/2015	Date of Injury:	12/29/2014
Decision Date:	12/24/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	10/08/2015

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: Minnesota, Florida

Certification(s)/Specialty: Orthopedic Surgery

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 43 year old female, who sustained an industrial injury on 12-29-2014. The injured worker was diagnosed as having impingement syndrome and rotator cuff tendinosis of the right shoulder, compensatory sprain-strain left shoulder, right lateral epicondylitis, and right wrist sprain-strain. Treatment to date has included medications. On 8-24-2015, the injured worker complains of bilateral shoulder pain, rated 10 out of 10, aggravated with overhead activities and lifting. She was currently taking Tylenol for pain after she reported being told of "bleeding internally due to using Aleve". Exam of the right shoulder noted Jamar grip strength 24-24-22 on the right and 28-26-28 on the left, decreased range of motion, and tenderness over the dorsum of the right wrist. She was to remain off work while awaiting authorization for right shoulder arthroscopy. The treatment plan included right shoulder arthroscopy and associated surgical services, noting Micro Cool unit rental x3 weeks, CPM rental x4 weeks, home therapy kit, and Vena Pro pneumatic compression device purchase. On 9-09-2015, Utilization Review certified the requested surgical procedure, modified the Micro Cool unit rental to 7 days, and non-certified the CPM rental, home therapy kit, and VenaPro pneumatic compression device purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Micro cool unit rental times 3 weeks: 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 Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Shoulder, Topic: Continuous flow cryotherapy.

Decision rationale: ODG guidelines recommend continuous-flow cryotherapy after shoulder surgery for 7 days. It reduces pain, swelling, inflammation, and the need for narcotics after surgery. Use beyond 7 days is not recommended. As such, the Micro-cool unit rental for 3 weeks is not supported by evidence-based guidelines and the medical necessity of the request has not been substantiated.

Associated surgical service: CPM fir rental times 4 weeks: 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) Section: Shoulder, Topic: Continuous Passive motion.

Decision rationale: With regard to continuous passive motion, ODG guidelines do not recommend routine use of CPM after shoulder arthroscopy for subacromial decompression or rotator cuff tears. As such, the request for the CPM unit rental for 4 weeks is not supported and the medical necessity of the request has not been established.

Associated surgical service: Home therapy kit: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care.

Decision rationale: California MTUS guidelines recommend instruction in home exercises for the shoulder except in cases of unstable fractures, acute dislocations, instability or hypermobility. The patients can be advised to do early pendulum or passive range of motion exercises at home. Instruction in proper exercise techniques is important and a few visits to a good physical therapist can serve to educate the patient about an effective exercise program. As such, the request for the home exercise kit is not supported and the medical necessity is not established.

VenaPro pneumatic compression device 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), Knee and Leg Chapter.

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

Decision rationale: The injured worker is undergoing shoulder surgery and the risk of deep vein thrombosis is extremely small. ODG guidelines do not recommend routine prophylaxis. However, in patients with a high risk of venous thrombosis, pharmacotherapy is recommended. The request as stated for the Venapro pneumatic compression device is not supported by guidelines and the medical necessity of the request has not been substantiated.