

Case Number:	CM15-0026414		
Date Assigned:	03/25/2015	Date of Injury:	04/05/2012
Decision Date:	05/08/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	02/11/2015

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

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 59-year-old female who reported injury on 04/05/2012. The documentation indicated the injured worker had been authorized for a repeat arthroscopy, rotator cuff repair, and SLAP repair of the left shoulder and postoperative physical therapy. The injured worker was authorized for an ultrasling with abduction pillow. The mechanism of injury was cumulative trauma. Prior therapies included physical therapy. The injured worker underwent an MRI of the shoulder. The documentation of 12/29/2014 revealed the injured worker had complaints of pain in the neck as well as the back. The injured worker had numbness and tingling into her arm. The physical examination revealed decreased range of motion of the left shoulder and a positive impingement sign. There was weakness in the left shoulder with abduction and external rotation. The injured worker's diagnoses included status post left shoulder arthroscopy with subacromial decompression and distal clavicle resection, full thickness rotator cuff tear, and type II SLAP tear, as well as a C5-6 and C6-7 discogenic pain with radiculopathy. The treatment plan included an epidural steroid injection for the cervical spine, a repeat surgery for the left shoulder, an internal medicine preoperative clearance, an RN assessment for postoperative wound care and home aid as needed, physical therapy, a motorized cold therapy unit, DVT unit, continuous passive motion machine, ultrasling with abduction pillow, and a pain pump.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-op Internal Medicine clearance: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Work Loss Data Institute.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Society of General Internal Medicine <http://www.choosingwisely.org/?s=preoperative+surgical+clearance&submit=>.

Decision rationale: Per the Society of General Internal Medicine Online, "Preoperative assessment is expected before all surgical procedures." The clinical documentation submitted for review indicated the injured worker had been approved for surgical intervention. This request would be appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur. Given the above, the request for Pre-op Internal Medicine clearance is medically necessary.

Post-operative RN Assessment for wound care and home aid: 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); Work Loss Data Institute.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

Decision rationale: The California Medical Treatment Utilization Schedule recommends home health services for injured workers who are homebound and who are in need of part time or "intermittent" medical treatment of up to 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. The clinical documentation submitted for review indicated the injured worker had been approved for surgical intervention. However, there is a lack of documentation indicating the injured worker would be home bound. Additionally, home aid is not recommended per the referenced guidelines. Given the above, the request for Post-operative RN Assessment for wound care and home aid is not medically necessary.

Motorized Cold Therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 Flow Cryotherapy.

Decision rationale: The Official Disability Guidelines indicate that continuous flow cryotherapy is recommended postoperatively for up to 7 days. The clinical documentation submitted for review indicated the injured worker would be undergoing surgical intervention. However, the request as submitted failed to indicate the frequency and whether the unit was for rental or purchase. Given the above, the request for Motorized Cold Therapy is not medically necessary.

Associated surgical services: DVT Unit: 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); Work Loss Data Institute.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Venous Thrombosis, Compression Garments.

Decision rationale: The Official Disability Guidelines indicate that injured workers should be assessed to indicate whether they are at risk for deep venous thrombosis. If found to be at risk, the injured worker should be considered for oral anticoagulation therapy. Additionally, the Official Disability Guidelines recommend compression garments for prevention of deep venous thrombosis. There was a lack of documentation indicating the injured worker was found to be at risk. The request as submitted failed to indicate whether the unit was for rental or purchase and the duration of use. Given the above, the request for associated surgical services: DVT Unit is not medically necessary.

Associated surgical service: Continuous Passive Motion (CPM) Machine: 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, Continuous passive motion (CPM).

Decision rationale: The Official Disability Guidelines indicate that continuous passive motion is not recommended for rotator cuff problems. It is recommended for adhesive capsulitis. The clinical documentation submitted for review failed to provide the injured worker had adhesive capsulitis. The documentation indicated the injured worker had rotator cuff issues. Additionally, the request as submitted failed to indicate whether the unit was for rental or purchase. Given the above, the request for Associated surgical service: Continuous Passive Motion (CPM) Machine is not medically necessary.

Associated surgical service: Pain Pump: 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) Shoulder Chapter, Postoperative pain pump.

Decision rationale: The Official Disability Guidelines do not recommend a postoperative pain pump. The clinical documentation submitted for review failed to provide documentation of exceptional factors. Given the above, the request for Associated surgical service: Pain Pump is not medically necessary.

Cervical Epidural Steroid Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

Decision rationale: The California MTUS Guidelines recommend epidural steroid injections when there is documentation of objective findings of radiculopathy upon physical examination that are corroborated by electrodiagnostics or imaging studies. There should be documentation of a failure of conservative care. The clinical documentation submitted for review failed to provide documentation of an MRI. There is a lack of documentation of objective findings upon examination to support the necessity for a cervical epidural steroid injection. There was a lack of documentation of a failure of conservative care. The request as submitted failed to indicate the specific level and laterality. Given the above, the request for Cervical Epidural Steroid Injection is not medically necessary.