

Case Number:	CM15-0050574		
Date Assigned:	03/24/2015	Date of Injury:	07/31/2000
Decision Date:	05/01/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/17/2015

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: Maryland, Virginia, North Carolina
 Certification(s)/Specialty: Plastic 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 57 year old female, who sustained an industrial injury on 7/31/2000. The medical records indicated multiple complaints from repetitive motion resulting in neck, back, wrist, shoulder, and knee and foot pain. She is status post bilateral carpal tunnel release. Diagnoses include chronic low back pain due to spondylolisthesis, radiculopathy, myofascial pain/spasm, cervicalgia with radiculopathy, and right shoulder pain versus rotator cuff issue. Treatments to date include anti-inflammatory, physical therapy, epidural injection, radiofrequency ablation, and steroid injections. Currently, they complained of chronic low back, leg, neck and right arm and right shoulder pain. Radiofrequency ablation 1/7/15 was reported 80% effective in relieving pain symptoms. On 1/15/15, physical examination documented no new acute findings. The plan of care included ablation with MRI of the right shoulder to rule out right shoulder derangement. The request received included right shoulder surgery and associated care including rental of a cold therapy unit for twenty one (21) days.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Service: Surgical Clearance with Treating Physician: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, low back pain, preoperative testing, general.

Decision rationale: The patient is a 57 year old female who was certified for shoulder surgery. Based on the medical documentation provided, it is reasonable to have some form of preoperative testing and/or history and physical examination. The UR had certified laboratory testing, EKG, CXR and UA. However, based on ODG guidelines, it is reasonable to have a history and physical examination performed that can then direct any appropriate testing. From ODG: An alternative to routine preoperative testing for the purpose of determining fitness for anesthesia and identifying patients at high risk of postoperative complications may be to conduct a history and physical examination, with selective testing based on the clinician's findings. Thus, preoperative medical clearance should be considered medically necessary.

Associated Surgical Service: 21 Day Rental of Cold Therapy 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).

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

Decision rationale: The patient was approved for shoulder surgery and continuous cold therapy should be considered medically necessary in the short term. A limited 7 day course is consisted with ODG guidelines. Postoperative use generally may be up to 7 days. Thus, a 21 day rental would fall outside of the recommended guidelines and should not be considered medically necessary.