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| Case Number: | CM15-0056010 | | |
| Date Assigned: | 04/01/2015 | Date of Injury: | 06/09/2013 |
| Decision Date: | 05/15/2015 | UR Denial Date: | 02/24/2015 |
| Priority: | Standard | Application Received: | 03/24/2015 |

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: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 57-year-old male who reported injury on 06/09/2013. The mechanism of injury was not provided. The injured worker's diagnoses included right shoulder impingement syndrome with partial thickness rotator cuff tear and adhesive capsulitis. The injured worker was noted to be certified for a right shoulder arthroscopy with arthroscopic rotator cuff repair versus debridement of the partial thickness tear, possible capsular release and manipulation under anesthesia. The request per the documentation on 02/02/2015 was for a motorized cold therapy unit, DVT unit, continuous passive motion machine, UltraSling with abduction pillow and pain pump as well as RN assessment for postoperative wound care and home aid as needed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Registered Nurse assessment for postoperative wound care and home aid as needed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

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 patients 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 failed to provide documentation the injured worker would have a necessity to be homebound. There was a lack of documentation indicating a necessity for postoperative wound care and home aid as needed. The term home aid failed to indicate the specific treatment necessary. The request as submitted failed to indicate the duration of care and quantity of visits. Given the above, the request for registered nurse assessment for postoperative wound care and home aid as needed is not medically necessary.

Motorized cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Compensation Shoulder Procedure Summary.

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 for up to 7 days postoperatively. The clinical documentation submitted for review indicated the injured worker had been approved for surgical intervention which would support the necessity for 7 days of motorized cold therapy. The request as submitted failed to indicate the body part, duration and whether the unit was for rental or purchase. Given the above, the request for motorized cold therapy unit is not medically necessary.

Deep Vein Thrombosis 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 Treatment in Workers' Compensation Shoulder Procedure Summary.

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, Venous Thrombosis, Compression Garments.

Decision rationale: The Official Disability Guidelines indicate that patients should be assessed for risk factors for formation of venous thrombosis. If found to be at risk, the patient should be considered for oral anticoagulation therapy. Additionally, they indicate that compression garments are not recommended for the shoulder. The clinical documentation submitted for

review failed to provide documentation the injured worker had been found to be at risk. The request as submitted failed to indicate the duration of use, and whether the unit was for rental or purchase and the rationale for the use of the unit. Given the above, the request for deep vein thrombosis unit is not medically necessary.

Continuous Passive Motion 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 Treatment in Workers' Compensation Shoulder Procedure Summary.

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, Continuous Passive Motion (CPM).

Decision rationale: The Official Disability Guidelines indicate that continuous passive motion machines are recommended postoperatively for adhesive capsulitis but not for shoulder rotator cuff problems. The clinical documentation submitted for review indicated the injured worker's diagnoses included adhesive capsulitis. However, the request as submitted failed to indicate the duration and the body part to be treated and whether the unit was for rental or purchase. Given the above, the request for continuous passive motion machine is not medically necessary. Per the referenced guidelines, the treatment for adhesive capsulitis is up to 4 weeks at 5 days per week.

Ultra sling with abduction pillow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Compensation Shoulder Procedure Summary.

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 abduction pillow sling.

Decision rationale: The Official Disability Guidelines indicate that a postoperative abduction pillow sling is recommended following the open repair of a large and massive rotator cuff tear. The clinical documentation submitted for review failed to indicate the injured worker was going to undergo a repair of a large and massive open rotator cuff tear. There was a lack of documentation of exceptional factors to warrant nonadherence to guidelines recommendations. Given the above, the request for ultra sling abduction pillow is not medically necessary.

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 Treatment in Workers' Compensation Shoulder Procedure Summary.

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 indicate that a postoperative pain pump is not recommended. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for pain pump is not medically necessary.