

Case Number:	CM15-0082764		
Date Assigned:	05/01/2015	Date of Injury:	08/14/2013
Decision Date:	06/01/2015	UR Denial Date:	04/13/2015
Priority:	Standard	Application Received:	04/27/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 50-year-old female, who sustained an industrial/work injury on 8/14/13. She reported initial complaints of left shoulder pain due to dislocation. The injured worker was diagnosed as having pain in joint, shoulder region; right rotator cuff tear. Treatment to date has included medication, surgery (left shoulder manipulation under anesthesia, arthroscopic debridement, and cortisone injection), diagnostics, and physical therapy. Currently, the injured worker complains of left shoulder pain that is described as aching. Per the primary physician's progress report (PR-2) on 4/2/15, examination revealed flexion and abduction of the shoulder is at 90 degrees with question of adhesive capsulitis post- surgery. The PR-2 on 8/15/14 there was a request for pneumatic appliance. The requested treatments include Retro (DOS 08/15/2014) Pneumatic appliance half leg, and Retro (DOS 08/15/2014) Intermittent limb comp device.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro (DOS 08/15/2014) Pneumatic appliance half leg # Qty: 2: 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 ODG, shoulder surgery, compression.

Decision rationale: The ACOEM, ODG and California MTUS do not specifically address the requested medication. The ODG does recommend compression services or cryotherapy after surgery for up to 14 days. However, the ODG does not recommend this service post shoulder surgery. The patient will be undergoing shoulder surgery and therefore the request is not certified. In addition, there is no indication in the clinical documentation of right leg surgery or lower extremity immobilization.

Retro (DOS 08/15/2014) Intermittent limb comp device #1 Qty: 1: 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 ODG, shoulder surgery, compression.

Decision rationale: The ACOEM, ODG and California MTUS do not specifically address the requested medication. The ODG does recommend compression services or cryotherapy after surgery for up to 14 days. However, the ODG does not recommend this service post shoulder surgery. The patient will be undergoing shoulder surgery and therefore the request is not certified.