

Case Number:	CM14-0216942		
Date Assigned:	01/06/2015	Date of Injury:	09/29/2014
Decision Date:	03/06/2015	UR Denial Date:	12/15/2014
Priority:	Standard	Application Received:	12/28/2014

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 60-year-old female who reported an injury on 09/29/2014. Mechanism of injury was not submitted for review. It was indicated in the submitted documentation that the injured worker had undergone an arthroscopic extensive chondroplasty, left glenoid and humeral head with abrasion to the glenoid. Subacromial decompression debridement of superior surface rotator cuff tear, labrum, and partial synovectomy left shoulder on 01/08/2015. Medications include ibuprofen and Flexeril. Other treatments consist of surgery, physical therapy, home exercise program, and medication therapy. On 01/29/2015, it was indicated that that the injured worker's shoulder was improving very slowly. Physical examination revealed that range of motion on abduction, forward flexion was 100 degrees, and external rotation was 45 degrees with no irritability. There was no edema or deficits upon examination. Medical treatment plan is for the injured worker to continue with postoperative physical therapy and medication therapy. The submitted requests were for cold therapy unit, rental or purchase, and shoulder kit. It was noted in the submitted documentation that the injured worker was initially certified for 7 days cold therapy unit rental. There was no rationale or Request for Authorization form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: cold therapy unit, rental or purchase: 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) Knee, continuous flow cryotherapy.

Decision rationale: The request for associated surgical service: cold therapy unit, rental or purchase is not medically necessary. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery for up to 7 days, including home use. The request for 1 cold therapy unit, rented or purchased unit, exceeds the recommendations of the guidelines. It is unclear if the injured worker had undergone the initial 7 day rental postsurgical of the cryotherapy unit. Furthermore, there were no other significant factors provided to justify the use outside of current guidelines. Given the above, the request would not be indicated. As such, the request is not medically necessary.

Associated surgical service: shoulder kit: 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 Exercise Page(s): 46-47.

Decision rationale: The request for associated surgical service: shoulder kit is not medically necessary. The California MTUS Guidelines state there is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs and do not exclude exercise. There was no sufficient evidence to support the commendation of any particular exercise regimen over any other exercise program. The Official Disability Guidelines also state that a home exercise kit is recommended. A specific shoulder home exercise program would locate 69% good outcome versus 24% in the same exercise, and 20% in patients in this specific exercise group subsequently chose to undergo surgery versus 63% of the controlled groups. It was noted that the injured worker had been provided postsurgical physical therapy, and was well versed in a home exercise program to address any deficits. However, it was not indicated or specified in the submitted requested as to which shoulder the kit would be used on. It was documented in the report that the injured worker had no complaints of shoulder pain. Given the above, the request would not be indicated. As such, the request is not medically necessary.