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| Case Number: | CM14-0217388 | | |
| Date Assigned: | 01/07/2015 | Date of Injury: | 10/23/2012 |
| Decision Date: | 05/28/2015 | UR Denial Date: | 11/20/2014 |
| Priority: | Standard | Application Received: | 12/29/2014 |

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, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 67-year-old male who reported an injury on 10/23/2012. The mechanism of injury was not stated. The current diagnoses include right shoulder pain and dysfunction, right shoulder impingement, right shoulder AC joint arthrosis, right shoulder recurrent rotator cuff tear and status post right shoulder surgery on 02/27/2014. The injured worker presented on 09/10/2014 with complaints of right shoulder stiffness and discomfort. Upon examination, there was tenderness at the anterior acromial margin, tenderness at the AC joint, 165 degree flexion, 35 degree extension, 110 degree abduction, 35 degree adduction, 40 degree internal rotation and 50 degree external rotation. Recommendations at that time included continuation of the home exercise program and current medication regimen. Consideration was also made for a revision right shoulder rotator cuff repair. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

DURABLE MEDICAL EQUIPMENT, POLAR CARE UNIT RENTAL OF 1 TO 2 WEEKS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder.

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 recommend continuous flow cryotherapy for up to 7 days following surgery. The current request for a 1 to 2 week rental would exceed guideline recommendations. As such, the request is not medically necessary.

PREOPERATIVE CLEARANCE, COMPLETE METABOLIC PANEL, PT, PTT, CBC ELECTROLYTES, CREATINE, GLUCOSE, CHEST X-RAY, AND EKG: 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) Low Back Chapter, Preoperative testing, general.

Decision rationale: The Official Disability Guidelines state the decision to order preoperative testing should be guided by the patient's clinical history, comorbidities and physical examination findings. There was no documentation of a significant medical history or any comorbidities to support the necessity of preoperative clearance. As the medical necessity has not been established, the request is not medically necessary.