

Case Number:	CM15-0015111		
Date Assigned:	02/03/2015	Date of Injury:	12/13/2013
Decision Date:	03/23/2015	UR Denial Date:	12/18/2014
Priority:	Standard	Application Received:	01/27/2015

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic 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 70 year old male, who sustained an industrial injury on 12/13/2013. Surgical intervention has included an anterior cervical discectomy and fusion at C4-5 and C5-6, performed on 06/10/2014. The diagnoses have included right shoulder impingement syndrome and rotator cuff tear with acromioclavicular joint arthrosis. Treatment to date has included medications, steroid injections, and physical therapy. Medications have included Norco and Naproxen. A progress note from the treating physician, dated 11/24/2014, documented a follow-up visit with the injured worker. The injured worker reported right shoulder pain with temporary improvement after injections. There was pain with activities of daily living. Pain was increased with reaching, pulling, and pushing. Right shoulder exam included decreased range of motion, tenderness over the acromioclavicular joint with positive arm adduction test, positive impingement sign, and abduction and external rotation weakness. The treatment plan included: right shoulder arthroscopy with arthroscopic rotator cuff repair, and distal clavicular resection; request for preoperative clearance; request for an RN assessment for postoperative wound care and home aid as needed; request for motorized cold therapy unit post-surgically; and follow-up evaluation as scheduled. On 12/18/2014 Utilization Review noncertified a request for post-operative RN assessment for wound care and home aide as needed; and modified a request for a motorized cold therapy unit purchase, to motorized cold therapy unit rental x 7 days. The CA MTUS and the ODG were cited. On 01/16/2015, the injured worker submitted an application for IMR.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post Operative RN assessment for wound care and home aide as needed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

Decision rationale: The California MTUS recommends home health services only for otherwise recommended treatment for patients who are homebound, on a part time or intermittent basis. 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. Guideline criteria have not been met. There is no clear rationale provided for home health wound care services versus prescribed self-management. There is no clear documentation as the type of home health services being recommended for this patient to establish medical necessity. Probable post-op. home bound status has also not been detailed and/or adequately/fully established. Therefore, this request is not medically necessary.

Motorized cold therapy unit purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

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

Decision rationale: The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous-flow cryotherapy is an option for up to 7 days in the post-operative setting following shoulder surgery. The 12/18/14 utilization review decision recommended partial certification of a cold therapy unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.