

Case Number:	CM15-0126532		
Date Assigned:	07/13/2015	Date of Injury:	09/23/2011
Decision Date:	08/10/2015	UR Denial Date:	06/08/2015
Priority:	Standard	Application Received:	06/30/2015

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 (IW) is a 57 year old male who sustained an industrial injury on 09/23/2011. The mechanism of injury and initial report of injury are not found in the records reviewed. The injured worker was diagnosed as having complete rupture of rotator cuff, and acromioclavicular joint arthritis. Treatment to date has included medications and diagnostic tests. Currently, the injured worker complains of pain in his shoulder. He has crepitus with range of motion of the shoulder and tenderness over the AC joint greater tuberosity as well as the supraspinatus fossa and the periscapular region. He has positive drop arm test, positive external rotation test, and positive lift off test. According to physician notes, a MRI of 10/19/2014 showed internal derangement and impingement of right shoulder with a full thickness right rotator cuff tear. The treatment plan is for arthroscopic right rotator cuff repair. A request for authorization is also made for the following: 1. Motorized cold therapy unit; 2. Deep vein thrombosis (DVT) unit; 3. Deep vein thrombosis (DVT) unit; 4. Ultra-sling with abduction pillow.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized cold therapy 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 (ODG), Shoulder, Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) cryotherapy.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. The ACOEM does recommend the at home local application of cold packs the first few days after injury and thereafter the application of heat packs. The Official Disability Guidelines section on cryotherapy states: Recommended as an option after surgery but not for nonsurgical treatment. The request is for post-surgical use however the time limit for request is in excess of recommendations. Per the ODG, cold therapy is only recommended for 7 days post operatively. The request does not specify an amount of time and this is in excess of this amount and therefore is not medically necessary.

Deep vein thrombosis (DVT) 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 (ODG), Shoulder, Venous thrombosis.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) DVT prevention.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. The ODG does not recommend DVT prevention after upper extremity surgery due to the low probability of occurrence. In addition, the ODG recommends pharmaceutical prevention over mechanical prevention in patients at high risk that would warrant DVT prevention. The patient has no contraindications to pharmaceutical prevention and therefore the request is not medically necessary.

Continuous passive motion (CPM) 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 (ODG), Shoulder, Continuous passive motion (CPM).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) CPM.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. The ODG does recommend continuous passive motion (CPM) after certain surgeries. However the recommended time of use is only for 28 days maximum. The request does not specify how long the unit would be used for and therefore the request cannot be medically necessary.

