

Case Number:	CM15-0179037		
Date Assigned:	09/21/2015	Date of Injury:	10/09/2013
Decision Date:	10/23/2015	UR Denial Date:	08/13/2015
Priority:	Standard	Application Received:	09/11/2015

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: Arizona, California

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 36-year-old female who sustained an industrial injury on 10-09-2013. Medical records indicate the worker had an injury to the shoulder and neck. Her diagnoses include wrist ECRB (extensor carpi radialis brevis) tenosynovitis as evidenced on MRI (right), Myofascial pain syndrome, Rotator cuff syndrome not otherwise specified (right) Bicipital tenosynovitis (right) Chronic Pain, and Radiculopathy. She was treated with a Right Shoulder Arthroscopy, Rotator Cuff Debridement, Subacromial Decompression (07-20-2015) Current medications include Tramadol, and Meloxicam, and postoperative hydrocodone. In the provider notes of 07-22-2015, the worker is situation post right shoulder surgery on 07-20-2015, and is taking Norco. The incisions are clean and dry. She is encouraged to use the arm sling and will start therapy. An intermittent pneumatic compression device post operatively that combines cold and compression is planned along with physical therapy and pain medications. A request for authorization was submitted on 08-03-2015 for Intermittent Pneumatic Compression. A utilization review decision 08-13-2015 non-certified the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Intermittent Pneumatic Compression: Upheld

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

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 and pg 10.

Decision rationale: According to the guidelines, cold compression is not recommended due to lack of evidence for its use. DVT is uncommon for upper extremity surgeries. The claimant is undergoing shoulder subacromial decompression. There is no mention of hypercoagulable risk factors. The length of treatment is not specified. The request for intermittent pneumatic compression is not medically necessary.