

Case Number:	CM15-0060594		
Date Assigned:	04/06/2015	Date of Injury:	12/01/2013
Decision Date:	05/29/2015	UR Denial Date:	03/02/2015
Priority:	Standard	Application Received:	03/30/2015

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: 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 69 year old male, who sustained an industrial injury on 12/01/2013, while employed as a grocery clerk. He reported that lifting boxes resulted in injury to his right shoulder and left wrist. The injured worker was diagnosed as having right shoulder impingement, sprains and strains of unspecified site of shoulder and upper arm, and sprain of wrist, unspecified site. Treatment to date has included diagnostics, right shoulder surgery on 2/03/2015, interferential unit, physical therapy, and medications. On 2/18/2015, the injured worker was documented as doing excellent post-operatively. Incisions were healed and the right shoulder was elevated to 150 degrees, and external rotation 50 degrees. Moderate rotator cuff weakness was noted. The patient underwent arthroscopic acromioplasty and resection distal clavicle of the right shoulder with debridement of the rotator cuff on 02/13/2015. Post-operative equipment included Continuous Passive Motion, cold therapy, interferential, and post-operative physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO Shoulder CPM soft goods - 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 (ODG), Shoulder - Continuous passive motion (CPM) - 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) Shoulder (Acute & Chronic), Continuous passive motion (CPM).

Decision rationale: The request for retro shoulder CPM soft goods purchase is not medically necessary. The patient was status post arthroscopic acromioplasty and resection of the distal clavicle with debridement of the rotator cuff on 02/13/2015. The Official Disability Guidelines do not recommend continuous passive motion for the treatment of rotator cuff tears after surgery or for nonsurgical treatment. Continuous passive motion is recommended by the guidelines for the treatment of adhesive capsulitis for up to 4 weeks. The provided documentation did not indicate that this patient had a diagnosis of adhesive capsulitis and continuous passive motion is not recommended after shoulder rotator cuff surgery. As such, the requested service is not supported. Therefore, the request for retro shoulder CPM soft goods purchase is not medically necessary.

RETRO Vascutherm unit (Cold compression device) - 30 days rental: 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) - 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) Shoulder (Acute & Chronic), Continuous-flow cryotherapy.

Decision rationale: The request for retro VascuTherm unit (cold compression device) 30 day rental is not medically necessary. The patient had arthroscopic acromioplasty and resection of the distal clavicle of the right shoulder with debridement of the rotator cuff on 02/13/2015. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery for up to 7 days. As such, the requested service, in its entirety, is not supported. Therefore, the request for retro VascuTherm unit (cold compression device) 30 days rental is not medically necessary.

RETRO Wrap for Vascutherm 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 (ODG), Shoulder - Continuous passive motion (CPM) - 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) Shoulder (Acute & Chronic), Continuous-flow cryotherapy.

Decision rationale: The request for retro wrap for VascuTherm unit purchase is not medically necessary. The patient had arthroscopic acromioplasty and resection of the distal clavicle of the right shoulder with debridement of the rotator cuff on 02/13/2015. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery for up to 7 days. As such, the requested service is not supported. Therefore, the request for retro wrap for VascuTherm unit purchase is not medically necessary.

RETRO Shoulder CPM - 30 days rental: 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) - 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) Shoulder (Acute & Chronic), Continuous passive motion (CPM).

Decision rationale: The request for retro shoulder CPM 30 days rental is not medically necessary. The patient was status post arthroscopic acromioplasty and resection of the distal clavicle with debridement of the rotator cuff on 02/13/2015. The Official Disability Guidelines do not recommend continuous passive motion for the treatment of rotator cuff tears after surgery or for nonsurgical treatment. Continuous passive motion is recommended by the guidelines for the treatment of adhesive capsulitis for up to 4 weeks. The provided documentation did not indicate that this patient had a diagnosis of adhesive capsulitis and continuous passive motion is not recommended after shoulder rotator cuff surgery. As such, the requested service is not supported. Therefore, the request for retro shoulder CPM 30 days rental is not medically necessary.