

Case Number:	CM15-0060665		
Date Assigned:	04/06/2015	Date of Injury:	09/23/2011
Decision Date:	05/29/2015	UR Denial Date:	03/09/2015
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

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 60 year old male patient who sustained an industrial injury on 09/23/2011. A secondary treating office visit dated 02/16/2015 reported subjective complaints of shoulder pain. He is diagnosed with right full thickness rotator cuff tear, and AC joint arthrosis. The plan of care involved arthroscopic versus open rotator cuff repair; preoperative clearance, RN assess for postoperative wound care and home aide; 12 sessions of post surgery physical therapy; motorized cold therapy unit, deep vein thrombosis unit, ultra sling with abduction pillow and pain pump. He is to return for follow up on 04/13/2015. He has undergone magnetic resonance imaging. An orthopedic surgical consultation dated 10/28/2013 reported a change in the plan of care to involve being a candidate for surgical intervention in the form of decompressive laminectomy with foraminotomies. The patient has subjective complaint of back pain, bilateral legs involving numbness. In addition, he reports symptom of urinary retention. The impression noted mild central canal stenosis and mild left neural foraminal stenosis; moderate central canal stenosis and mild bilateral neural foraminal stenosis. He is diagnosed with L3-4, L4-5 stenosis with neurogenic claudication in addition to his shoulder injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

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 Shoulder, Deep vein thrombosis.

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, Venous thrombosis.

Decision rationale: According to the Official Disability Guidelines, the use of a deep vein thrombosis unit is not commonly utilized for injured workers undergoing a shoulder procedure. In the case of this injured worker, there was no confirmation that he had been authorized for a surgical repair of the right shoulder rotator cuff tear and AC joint arthrosis. His most recent clinical documentation was dated 02/16/2015 which did report subjective complaints of shoulder pain with his MRI from 10/2014 identifying the full thickness tear. However, without confirmation that he has been certified for undergoing the requested surgical procedure and without having a date of operation set, the current request for a deep vein thrombosis unit is not considered medically necessary.

Continuous passive motion (CPM) machine: Upheld

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

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 passive motion (CPM).

Decision rationale: According to the Official Disability Guidelines, a continuous passive motion machine is not supported for use after undergoing a shoulder procedure. Additionally, the most recent clinical documentation did not identify that the injured worker had been authorized for undergoing the rotator cuff repair. There was evidence that he was to be re-evaluated in 04/2015 with no further documentation provided for review. Therefore, without clarification that the injured worker will be undergoing a surgical procedure in the near future, and without support for the use of a CPM machine for treatment of the shoulder, the requested service is not considered medically necessary at this time.

Ultra sling with abduction pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder, Postoperative Abduction Pillow Sling.

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, Postoperative Abduction Sling.

Decision rationale: According to the Official Disability Guidelines, although an Ultra Sling with abduction pillow is commonly utilized postoperatively for injured workers undergoing a rotator cuff procedure, without confirmation that the injured worker has been authorized for a surgical repair of his shoulder, the Ultra Sling cannot be supported at this time. The guidelines indicate that this type of Ultra Sling with the abduction pillow is utilized for injured workers who have undergone an open procedure for a massive rotator cuff tear. Although the injured worker was identified as having a full thickness tear of the rotator cuff, there was no evidence that he has been authorized for an open procedure to warrant the use of the Ultra Sling and abduction pillow at this time. The medical necessity has not been established.

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 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: Official Disability Guidelines indicate that a continuous flow cryotherapy may be utilized for up to 7 days postoperatively including in home use. However, there was no confirmation that the injured worker had been authorized for undergoing any type of surgical procedure to warrant the use of a motorized Cold Therapy Unit. Additionally, the physician failed to specify the duration of use of the device. As such, the medical necessity has not been established.