

Case Number:	CM13-0023634		
Date Assigned:	11/15/2013	Date of Injury:	03/06/2011
Decision Date:	02/14/2014	UR Denial Date:	08/27/2013
Priority:	Standard	Application Received:	09/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine, and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 applicant is a represented [REDACTED] employee who has filed a claim for chronic shoulder pain reportedly associated with an industrial injury of March 6, 2011. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; transfer of care to and from various providers in various specialties; prior shoulder surgery on February 8, 2013; and extensive periods of time off of work, on total temporary disability. In a utilization review report of August 27, 2013, the claims administrator denied a request for a continuous cooling device, a pain pump, continuous passive motion machine, physical therapy, Zofran, and omeprazole. Naprosyn was approved. The applicant's attorney later appealed. The operative report of February 8, 2013 is reviewed. The applicant underwent revision arthroscopy, subacromial decompression, arthroscopic resection of coracoacromial ligament, and distal clavicle resection with pain pump insertion on that date. On May 7, 2013, it was stated that the claimant was clinically doing remarkably well. The claimant only had minimal discomfort, full, painless, cervical range of motion is noted. Shoulder flexion and abduction were limited to 160 degrees with 4+/5 shoulder strength noted. The claimant was deemed permanent and stationary. He has apparently returned to regular duty work and was given an 11% whole person impairment rating. He is asked to follow up as needed

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective pain pump: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The MTUS does not address the topic. The ODG shoulder chapter postoperative pain pump topic states that postoperative pain pumps are "not recommended" as the analgesia does not differ markedly from that associated with standard oral medications. In this case, the attending provider did not furnish any compelling rationale or narrative so as to try and offset the unfavorable MTUS recommendation. Therefore, the request is not certified.

Iceman cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The MTUS does not address the topic of continuous flow cryotherapy following shoulder surgery. As noted in the ODG shoulder chapter continuous flow cryotherapy topic, continuous flow cryotherapy is recommended as an option for up to seven days postoperatively. In this case, however, the request, as made, is for purchase of this unit. This is not indicated as ODG notes that complications associated with long-term cryotherapy usage can include frostbite. Frostbite can be quite devastating, it is further noted. Thus, purchase of the unit cannot be endorsed here.

DailyStim use: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 116.

Decision rationale: As noted on page 116 of the MTUS Chronic Medical Treatment Guidelines, TENS unit/electrical stimulation can be recommended as a treatment option for acute postoperative pain during the first 30 days following surgery. In this case, the attending provider intended this stimulation to take place immediately postoperatively. This is a usage which is endorsed by the MTUS. Therefore, the request is certified. While this is, strictly speaking, a postoperative case as opposed to a chronic pain case, MTUS 9792.23.b.2 does afford the reviewer with an opportunity to select guidelines found anywhere within the MTUS along with

those guidelines in section 9792.24.3 to govern treatment during the postsurgical treatment window.

CPM: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

Decision rationale: The MTUS does not address the topic. As noted in the third edition ACOEM Guidelines, continuous passive motion (CPM) is recommended as part and parcel of rehabilitation for those individuals who carry a diagnosis of adhesive capsulitis. In this case, however, there is no evidence that the claimant in fact carries a diagnosis of adhesive capsulitis. The operative report suggested that the principal diagnosis was that of partial rotator cuff tear. CPM is not indicated in the treatment of the same. Therefore, the request is not certified.

12 sessions of physical therapy: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: As noted in MTUS 9792.24.3.c.3, an initial course of postoperative treatment should comprise of one half of the general course of treatment. If there is documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. In this case, an overall general course of 24 sessions of treatment is recommended following rotator cuff repair surgery. In this case, the claimant did ultimately effect appropriate functional improvement following shoulder surgery. The claimant ultimately returned to regular duty and affected a marked recovery in terms of diminished physical impairment, it was further noted. He was declared permanent and stationary approximately three to four months after the date of the surgery. Thus, in this case, the claimant's favorable response to physical therapy did justify the 12 additional sessions of postoperative treatment for which authorization was sought. Therefore, the request is retrospectively certified.

Omeprazole: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 69.

Decision rationale: As noted on page 69 of the MTUS Chronic Medical Treatment Guidelines, proton-pump inhibitor such as omeprazole are indicated in the treatment of NSAID-induced dyspepsia. In this case, however, there is no clear evidence of dyspepsia NSAID-induced or stand-alone. Therefore, the request is not certified.

Zofran: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The MTUS does not address the topic. As noted in the ODG Chronic Pain chapter antiemetics topic, antiemetics such as Zofran are FDA approved in the treatment of post-operative or perioperative nausea. In this case, the request for Zofran was intended for peri-operative/post-operative purposes. Therefore, the original utilization review decision is overturned. The request is certified.