MAXIMUS Federal Services

Case Number:	CM13-0064207		
Date Assigned:	01/03/2014	Date of Injury:	07/26/2012
Decision Date:	05/19/2014	UR Denial Date:	11/20/2013
Priority:	Standard	Application Received:	12/11/2013

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 Physical Medicine & Rehabilitation, 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 patient is a 30 year old male who was injured on 07/26/2012 who due to repetitive work, he developed a left shoulder and neck pain. The patient's position was that the keyboard was in front of him and the monitor was to the right. Prior treatment history has included the patient undergoing left shoulder arthroscopy with acromioplasty, Mumford distal clavicle resection and superior labral repair. The patient's medications include: 1) Hydrocodone 10/325 mg; 2) Diclofenac sodium 100 mg; 3) Pantoprazole sodium 20 mg; and 4) Cyclobenzaprine 7.5 mg. Diagnostic studies reviewed include X-ray of the right shoulder dated 07/26/2012 revealing normal architecture and alignment. No fracture or osseous lesion identified. Normal joints without evidence of arthritis or effusion. Unremarkable soft tissue. MRI of the left shoulder dated 05/08/2013 revealed the following: 1) Arthrosis of the acromioclavicular joint. Type II acromion. Extrinsic impingement on the transversing underlying supraspinatus. 2) No rotator cuff tendon tear. 3) SLAP tear. 4) Increased signal transversing the anterior labrum consistent with a tear, consider Perthes lesion versus soft tissue Bankart lesion. 5) No fracture or dislocation. PR-2 dated 08/05/2013 documented the patient to have complaints of left shoulder pain. He is here today to discuss pre-operative and post-operative surgical instructions. He is to have a left shoulder arthroscopy with acromioplasty, Mumford distal clavicle resection and superior labrum repair. Objective findings on exam the MRI exam reveals left shoulder impingement. Diagnoses: 1) Rotator cuff tear left shoulder; and 2) Pain in joint.

IMR ISSUES, DECISIONS AND RATIONALES

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

PAIN PUMP: 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 - PAIN PUMP.

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 AND CHRONIC), POSTOPERATIVE PAIN PUMP.

Decision rationale: The California MTUS guidelines do not discuss the issue in dispute and hence the ODG have been consulted. According to the ODG, "three recent rotator cuff tears (RCTs) did not support the use of these pain pumps. This study neither supports nor refutes the use of infusion pumps. This study concluded that infusion pumps did not significantly reduce pain levels." The request is for pain pump for postoperative recovery; however, the guidelines do not support its use and hence the request is non-certified.

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), SHOULDER (ACUTE AND CHRONIC), CONTINUOUS-FLOW CRYOTHERAPY.

Decision rationale: According to the MTUS guidelines, "home, local application of cold during first few days of acute complaint; thereafter, then heat application." According to the ODG, cryotherpay is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g, muscle strains and contusions) has not been fully evaluated. In this case, this employee has left shoulder pain and had left shoulder arthroscopic surgery on 08/09/2013. The guidelines recommend postoperative cold unit for 7 days and the provider has requested cold therapy unit for postoperative recovery; however, the request is not specific regarding the number of days for use. Also, there is no objective findings documented to warrant the use of the cold unit and hence the request is non-certified.

IMMOBILIZER: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-213.

Decision rationale: According to the California MTUS guidelines, brief use of a sling for severe shoulder pain (1 to 2 days), with pendulum exercises to prevent stiffness in cases of rotator cuff conditions (D)' three weeks use, or less, of a sling after an initial shoulder dislocation and reduction (C); and same for AC separations or severe sprains (D). The prolonged use of a sling only for symptom control is not recommended. In this case, this employee has left shoulder pain with MRI evidence of no fracture or dislocation, or RCT. The employee had left shoulder arthroscopic surgery on 08/09/2013. There is no documentation of objective findings or functional limitations to warrant the need for immobilizer. Thus, the medical necessity has not been established and the request is non-certified.

SHOULDER CONTINUOUS PASSIVE MOTION: 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), SHOULDER (ACUTE AND CHRONIC), CONTINUOUS PASSIVE MOTION (CPM).

Decision rationale: The California MTUS guidelines do not address the issue in dispute and hence the ODG have been consulted. According to the ODG, "Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week." In this case, this employee has left shoulder pain with MRI evidence of no fracture/dislocation, AC arthrosis, impingement, SLAP tear, and no RCT. He had left shoulder arthroscopic surgery on 08/09/2013. There is neither documentation of physical exam findings consistent with adhesive capsulitis nor the diagnosis of adhesive capsulitis has been established. Thus, the medical necessity has not been established and the request is non-certified.