

Case Number:	CM13-0064212		
Date Assigned:	01/03/2014	Date of Injury:	05/06/2013
Decision Date:	05/16/2014	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 an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Anesthesiology has a subspecialty in Pain Management 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 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/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:

According to the records made available for review, this is a 47-year-old female with 5/6/13 date of injury, and left shoulder arthroscopy, synovectomy, acromioplasty, and subacromial pain pump insertion 11/11/13. At the time (9/27/13) of request for authorization for Purchase Of Shoulder Continuous Passive Motion (CPM) and Post Operative Pain Pump, there is documentation of subjective (continued left shoulder pain) and objective (severe pain with palpation of the subacromial space, positive impingement sign, and abduction and forward flexion are limited to 100 degrees) findings, current diagnoses (left shoulder arthroscopy, synovectomy, acromioplasty, and subacromial pain pump insertion and left shoulder impingement syndrome), and treatment to date (12 visits of physical therapy, anti-inflammatory medications, and left shoudler surgery). Regarding CPM, there is no documentation of adhesive capsulitis.

IMR ISSUES, DECISIONS AND RATIONALES

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

PURCHASE OF SHOULDER CONTINUOUS PASSIVE MOTION (CPM): 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 CHAPTER

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: MTUS does not address the issue. ODG identifies documentation of adhesive capsulitis up to 4 weeks/5 day per week, as criteria necessary to support the medical necessity of continuous passive motion. ODG also notes that continuous passive motion is not recommended for shoulder rotator cuff problems, after shoulder surgery, or for nonsurgical treatment. Within the medical information available for review, there is documentation of diagnoses of left shoulder arthroscopy, synovectomy, acromioplasty, and subacromial pain pump insertion and left shoulder impingement syndrome. In addition, there is documentation of a recent surgery that was medically necessary. However, there is no documentation of adhesive capsulitis. Therefore, based on guidelines and a review of the evidence, the request for Purchase of Shoulder Continuous Passive Motion (CPM) is not medically necessary.

POST OPERATIVE 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 CHAPTER

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) SHOULDER, POSTOPERATIVE PAIN PUMP

Decision rationale: MTUS does not address this issue. ODG identifies that post-operative pain pump is not recommended and that there is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular, or intravenous measure. Therefore, based on guidelines and a review of the evidence, the request for Post Operative Pain Pump is not medically necessary.