

Case Number:	CM13-0067911		
Date Assigned:	01/03/2014	Date of Injury:	06/20/2011
Decision Date:	04/11/2014	UR Denial Date:	12/09/2013
Priority:	Standard	Application Received:	12/18/2013

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 Orthopedic Surgery 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:

This claimant is a 56-year-old female who sustained a shoulder injury on June 20, 2011. The records provided for review documented a working diagnosis of bilateral shoulder impingement syndrome and that the claimant had failed conservative care. A right shoulder subacromial decompression and debridement was recommended. The specific requests at present are for postoperative use of a ThermoCool system for 60 days, a home health registered nurse four (4) hours daily for two (2) weeks, and a three (3) to five (5) day use of a pain pump in the postoperative setting for the surgical process.

IMR ISSUES, DECISIONS AND RATIONALES

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

POSTOPERATIVE USE OF A PAIN PUMP FOR THREE (3) TO FIVE (5) DAYS: 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 (Acute & Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Treatment in Worker's comp; 18th edition; 2013 Updates; Chapter Shoulder: Postoperative pain pump

Decision rationale: The California MTUS and ACOEM Guidelines are silent. Based upon the Official Disability Guideline criteria, a pain pump would not be indicated. The Official Disability Guidelines and current scientific literature does not support the current role of pain pumps in the postoperative setting. The specific request for this postoperative modality given the claimant's clinical picture and surgical request would not be supported.

HOME HEALTH NURSE (RN), FOUR (4) HOURS DAILY FOR TWO (2) WEEKS:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

Decision rationale: According to the California MTUS Guidelines, home health care is indicated for patients who are homebound on a part-time or intermittent basis. The claimant is scheduled to undergo an arthroscopic procedure to include a subacromial decompression of the shoulder. The medical records reviewed do not indicate why the claimant would require home care assistance by an RN for four hours per day for two weeks. Therefore, the specific request for a two-week use of a home health registered nurse for the surgical process in question would not be indicated.

POSTOPERATIVE USE OF A THERMOCOOL SYSTEM FOR 60 DAYS: 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 (Acute & Chronic)

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

Decision rationale: The California MTUS and ACOEM Guidelines are silent. When looking at Official Disability Guideline criteria, combination therapy devices including ThermoCool units are not supported. The clinical literature does support the isolated role of a cryotherapy device alone for a seven-day use for the shoulder in the postoperative setting. The clinical literature does not support the role of combination therapy devices as requested in this case or for frequency being requested. The specific request is not supported.

POSTOPERATIVE USE OF A CONTINUOUS PASSIVE MOTION (CMP) 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 (ODG) shoulder (Acute & Chronic)

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

Decision rationale: The California MTUS and ACOEM Guidelines are silent. Based upon the Official Disability Guidelines, the request for a Continuous Passive Motion Machine after surgery cannot be recommended as medically necessary. The Official Disability Guidelines do not support the use of a continuous passive motion machine following surgery.