

<b>Case Number:</b>	CM13-0068121		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	08/29/2012
<b>Decision Date:</b>	04/10/2014	<b>UR Denial Date:</b>	11/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2013

### 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 Internal Medicine & Emergency Medicine, and is licensed to practice in Florida. 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:

This patient is a 52 year-old with a date of injury of 08/29/12. A progress report associated with the request for services, dated 10/28/13, identified subjective complaints of pain in both shoulders, left greater than right. Objective findings included tenderness of the shoulder with signs of impingement. Diagnoses included bilateral shoulder impingement syndrome. Treatment has included injections and Physical Therapy. A left shoulder arthroscopy with subacromial decompression and debridement has been approved. A Utilization Review determination was rendered on 11/15/13 recommending non-certification of "Home Health Care for wound cleaning and assistance 4 hours daily times 2 weeks; implantation of pain pump in the subacromial space post op; DVT prophylaxis; [REDACTED] hot and cold contrast therapy with compression; COMBO care 4; CMP times 30 days; ultra sling with abduction pillow".

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home Health Care for wound cleaning and assistance 4 hours daily times 2 weeks:** 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 Home Health Services Page(s): 51.

**Decision rationale:** The Medical Treatment Utilization Schedule (MTUS) only recommends home health services for those patients that are homebound. An uncomplicated arthroscopic subacromial decompression normally does not require home health services postoperatively. Therefore, in this case, there is no documented medical necessity for home health services.

**Implantation of pain pump in the subacromial space post op:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, 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:** The Medical Treatment Utilization Schedule (MTUS) does not address intra-articular postoperative pain pumps. The Official Disability Guidelines (ODG) state that postoperative pumps are not recommended. Multiple randomized controlled trials have failed to support the efficacy of these pain pumps. Therefore, in this case, there is no documented medical necessity for a postoperative intra-articular pain pump.

**Deep vein thrombosis (DVT) prophylaxis:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, 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, Venous Thrombosis

**Decision rationale:** The Medical Treatment Utilization Schedule (MTUS) does not address the use of postoperative deep venous thrombosis (DVT) prophylaxis. The Official Disability Guidelines (ODG) notes that the risk for DVT is low with shoulder surgery. They further state that administration of DVT prophylaxis is not generally recommended in shoulder arthroscopy procedures. In this case, there are no high-risk features identified in the record. Therefore, there is no documented medical necessity for postoperative DVT prophylaxis.

**hot and cold contrast therapy with compression:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203; 212.

**Decision rationale:** [REDACTED] hot and cold contrast therapy with compression is a device that provides alternating hot and cold therapy with associated wraps for compression. The Medical Treatment Utilization Schedule (MTUS) states that at-home applications of heat or cold packs to aid exercises are optional. There is no recommendation for alternating heat and cold using a device other than non-mechanical application of heat or cold packs. Therefore, in this case, there is no documented medical necessity for a [REDACTED] device.

**COMBO care 4:** 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 Chronic Pain Medical Treatment Guidelines Interferential Current Stimulation; NMES; TENS; Transc.

**Decision rationale:** Neuromuscular electrical stimulation (NMES) is not recommended. It is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. In this case, the Combo Care 4 unit is being requested for a type of application not indicated for treatment. Last, the Combo Care 4 uses some modalities that are not recommended. Therefore, there is no documented medical necessity for a Combo Care 4 unit.

**CMP times 30 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)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous Passive Motion

**Decision rationale:** The Medical Treatment Utilization Schedule (MTUS) states that passive modalities are not recommended for the shoulder. The Official Disability Guidelines (ODG) state that continuous passive motion is not recommended after shoulder surgery for rotator cuff tears. Therefore, there is no documentation for the medical necessity of a continuous passive motion device.

**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 (ODG) Official Disability Guidelines

**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 Abduction Pillow Sling

**Decision rationale:** The Medical Treatment Utilization Schedule (MTUS) does not address postoperative abduction pillows. The Official Disability Guidelines (ODG) state that they are recommended as an option following repair of large or massive rotator cuff tears and are not used for arthroscopic repairs. Therefore, in this case, there is no documentation for the medical necessity of an abduction pillow sling.