

Case Number:	CM14-0010584		
Date Assigned:	05/30/2014	Date of Injury:	12/12/2009
Decision Date:	07/25/2014	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	01/27/2014

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, has a subspecialty in Shoulder and Elbow 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:

The injured worker is a 35 year old male with reported injury on 12/12/2009. The mechanism of injury was not provided. The injured worker had an examination on 12/27/13 with complaints of continuous pain to left shoulder with limited range of motion and numbness and tingling to left hand. He had a positive O'briens sign. The x-rays revealed left humerus impingement sign. The recommended plan of treatment is left shoulder arthroscopy rotator cuff repair. The injured worker had a follow-up examination on 01/27/2014 with complaints of left wrist falling asleep after he had a carpal tunnel release. The diagnoses was instability. The recommended plan of treatment was injection with ultrasound. There was no medication list or efficacy provided. There was no documentation of physical therapy or home exercise program. There was no mention of a pain pump, electrical stimulation unit or continuous passive motion. The request for authorization and the rationale was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

POSTOPERATIVE 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 (ACUTE AND CHRONIC).

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

Decision rationale: The request for pain pump is non-certified. The injured worker had an injury on 12/12/2009. He had a recommendation of rotator cuff repair on 12/27/2013. The Official Disability Guidelines do not recommend a postoperative pain pump for the shoulder. There is no evidence of pain management, medications, physical therapy or home exercise program. Furthermore, the request does not specify dose and duration. Therefore the request for pain pump is non-certified.

ELECTRICAL STIM UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NEUROMUSCULAR ELECTRICAL STIMULATION Page(s): 121.

Decision rationale: The request for electrical stimulation unit is non-certified. The injured worker had an injury of 12/12/2009. He had a recommendation for shoulder rotator cuff repair on 12/27/2013. The California MTUS Guidelines do not recommend a neuromuscular electrical stimulator. The guidelines state the stimulator is used primarily as a part of a rehabilitation program following a stroke, there is no evidence to support its use in chronic pain. There was no evidence provided that the injured worker had a stroke. There was no documentation provided regarding medications, physical therapy or home exercise program. Furthermore, the request did not specify frequency and duration of the stimulator. Therefore, the request for electrical stimulation is non-certified.

CPM (CONTINUOUS PASSIVE MOTION) MACHINE FOR THE LEFT SHOULDER:
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 AND 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, CONTINUOUS PASSIVE MOTION.

Decision rationale: The request for CPM to left shoulder is non-certified. The injured worker had an injury on 12/12/2009. The injured worker was recommended to have rotator cuff repair on 12/27/2013. The Official Disability Guidelines do not recommend continuous passive motion for shoulder rotator cuff problems. The guidelines state it is not recommended after shoulder surgery or for nonsurgical treatment. There was no documentation provided regarding medications, physical therapy or home exercise program. Furthermore, the request did not

provide specific instructions as to frequency and duration. Therefore, the request for CPM is non-certified.