

Case Number:	CM14-0153677		
Date Assigned:	09/23/2014	Date of Injury:	04/19/2012
Decision Date:	10/24/2014	UR Denial Date:	09/19/2014
Priority:	Standard	Application Received:	09/19/2014

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 Physical Medicine and Rehabilitation, 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:

This is a female patient with a date of injury of April 19, 2012. A utilization review determination dated September 16, 2014 recommends noncertification of a shoulder CPM x 21 days, pain pump, and Hako Med x5. A progress note dated August 27, 2014 identify subjective complaints of intractable shoulder pain, the pain is described as sharp, stabbing and constant. The severity of the pain symptoms are described as moderate to severe with profound limitations; the pain is aggravated by keyboarding, reaching, pushing, pulling, lifting, and carrying heavy objects. Associated symptoms include stiffness, weakness, and headache. Surgery is indicated at this time due to decreased pain and failure of conservative care, therapeutic goals are not being met at this time. Current medications include Anaprox-DS, Ultram ER, and cyclobenzaprine. Physical examination identifies tenderness to the anterior shoulder and to the the scapular region, spasms and swelling of trapezius, decreased range of motion in all ranges, positive cross chest tests, positive AC joint compression test, positive Neer impingement sign, and positive Hawkins impingement sign. The diagnoses include impingement syndrome-right, and rotator cuff tear-left. The treatment plan recommends a request for a left shoulder arthroscopic acromioplasty with distal claviclectomy and rotator cuff repair, and as part of the post operative protocol a request for an ART unit, pain pump, cold therapy, CPM machine, an abduction brace, and postoperative physical therapy for three times per week for four weeks. The treatment plan also recommends a preoperative chest x-ray, EKG, urinalysis, comprehensive metabolic panel, and CBC.

IMR ISSUES, DECISIONS AND RATIONALES

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

SHOULDER CPM 21 DAYS RENTAL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment 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 Chapter, Continuous passive motion (CPM) X Official Disability Guidelines (ODG), Shoulder Chapter, Continuous passive motion (CPM)

Decision rationale: Regarding the request for a shoulder CPM machine X 21 days, California MTUS and ACOEM guidelines do not contain criteria for the use of this device. ODG states that CPM machines are not recommended for shoulder rotator cuff problems, but are recommended as an option for adhesive capsulitis for up to 4 weeks/5 days per week. ODG states continuous passive motion is not recommended after shoulder surgery or for nonsurgical treatment. Within the documentation available for review, there is no indication that the patient has adhesive capsulitis. As such, the currently requested shoulder CPM machine X 21 days is not medically necessary.

PAIN PUMP: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment 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 Chapter, Postoperative pain pump

Decision rationale: Regarding the request for a pain pump, California MTUS does not address the issue. ODG cites that postoperative pain pumps are not recommended for the shoulder, as 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 measures. In light of the above issues, the currently requested pain pump is not medically necessary.

HAKOMED X 5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

Decision rationale: Regarding the request for Hako Med x 5, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an

isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions that limits the ability to perform exercises, or unresponsive to conservative treatment.). Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement. In light of the above issues, the currently requested Hako Med x5 is not medically necessary.