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| Case Number: | CM14-0158593 | | |
| Date Assigned: | 10/02/2014 | Date of Injury: | 02/01/2011 |
| Decision Date: | 11/06/2014 | UR Denial Date: | 09/24/2014 |
| Priority: | Standard | Application Received: | 09/26/2014 |

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 Family Practice 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 patient is a 57 year old female LVN who sustained an industrial injury on 2/1/2011. 8/7/14 right shoulder MRI was positive for full thickness tear of right supraspinatus tendon and degenerative type tear superior glenoid labrum. The patient was seen on 9/17/14 and right shoulder surgery was recommended. On 9/30/14 the patient underwent right shoulder arthroscopic acromioplasty, arthroscopic distal claviclectomy, arthroscopic synovectomy to include subacromial bursectomy and intraarticular synovectomy, arthroscopic aided rotator cuff repair and tenodesis of the long head of the biceps. On 9/24/14 peer review certified the request for right shoulder arthroscopy with acromioplasty, distal claviclectomy and rotator cuff repair, shoulder abduction sling, cold therapy unit x 7 days and post-op PT 3x4 right shoulder. The request for post-operative Hako-Med therapy 1x 5 right shoulder, CPM machine/kit x 21 day rental (rental or purchase), and pain pump was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-Op HAKO-Med Therapy (Right Shoulder): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Horizontal therapy (HT), Interferential Current Stimulation (ICS) Page(s): 51 54.

Decision rationale: Hako Med therapy is Horizontal Electro-therapy. The CA MTUS address horizontal electro-therapy and refers one to ICS. Per the CA MUTS guidelines, "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.)." In this case, the medical records do not establish that the patient is unable to effectively participate in post-operative rehabilitation. There is also no evidence that pain is not controlled with medication or that there is a history of substance abuse. As such, the request for Post-Op HAKO-Med Therapy (Right Shoulder) is not medically necessary.

CPM Machine/Kit X 21 Day Rental (Rental or Purchase): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder Procedure Summary Updated 08/27/2014 CPM

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CPM unit. Decision based on Non-MTUS Citation Shoulder, Continuous passive motion (CPM)

Decision rationale: According to ODG, continuous passive motion (CPM) is not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. ODG notes, "Rotator cuff tears: Not recommended after shoulder surgery or for nonsurgical treatment. (Raab, 1996) (BlueCross BlueShield, 2005) An AHRQ Comparative Effectiveness Review concluded that evidence on the comparative effectiveness and the harms of various operative and nonoperative treatments for rotator cuff tears is limited and inconclusive. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain, and one study found no difference in range of motion or strength. (Seida, 2010)" Evidence based guidelines do not recommend post-operative use of CPM unit. It is noted that post-operative PT has been certified, and it is expected that range of motion can be regained through post-op with. The request for CMP unit is not medically necessary.

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 Shoulder Procedure Summary Updated 08/27/2014 Operative Pain Pumps

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines pain pump. Decision based on Non-MTUS Citation Shoulder, Postoperative pain pump

Decision rationale: As noted in ODG, postoperative pain pump is not recommended, and three recent moderate quality RCTs did not support the use of pain pumps. Evidence based guidelines do not recommend post-operative pain pump for shoulder surgeries. Therefore, the request for pain pump is not medically necessary.