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| Case Number: | CM14-0028290 | | |
| Date Assigned: | 06/20/2014 | Date of Injury: | 01/05/2011 |
| Decision Date: | 08/04/2014 | UR Denial Date: | 01/14/2014 |
| Priority: | Standard | Application Received: | 02/17/2014 |

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 Surgeon and is licensed to practice in Texas. 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 53-year-old female who reported an injury due to repetitive use of the right wrist and right shoulder on 01/06/2011. In the clinical notes dated 12/19/2013, the injured worker complained of right shoulder pain. Prior treatments included physical therapy, medications, injections, and rest. The physical examination of the right shoulder revealed a motor strength for the supraspinatus on the right 4+/5 and the left 5/5; a positive impingement test I; positive impingement test II; and a positive drop arm test. A grip and capacity measurement showed the right hand at 20/20/10 and the left at 50/50/40. An x-ray of the right shoulder and humerus revealed spurring on the undersurface of the acromion with acromioclavicular joint degenerative changes. The diagnosis included clinical and a MRI scan evidence of a significant partial thickness tear of the rotator cuff with impingement syndrome. The treatment plan included a request for a diagnostic and operative arthroscopy of the right shoulder with PASTA repair and acromioplasty. The request for authorization for a cold therapy unit purchase, pain pump purchase, shoulder immobilizer purchase, and an electrical stimulation unit purchase for a rotator cuff tear to the right shoulder was submitted on 01/07/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

POST-OP COLD THERAPY UNIT ; 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 (ODG) Shoulder chapter - continuous - flow Cryotherapy.

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-flow cryotherapy.

Decision rationale: The require for a postoperative cold therapy unit purchase is not medically necessary. The ODG state that continuous flow cryotherapy is recommended as an option after surgery. The postoperative use generally would be up to 7 days to include home use. In the postoperative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. In the clinical notes provided for review, there is a lack of documentation of the authorization for the right shoulder rotator cuff repair. There is also a lack of documentation of the injured worker's pain level status with or without the use of pain medications. Furthermore, the guidelines recommend continuous flow cryotherapy; however, it is only up to 7 days to include home use. Therefore, the request for postoperative cold therapy unit purchase is not medically necessary.

POST-OP PAIN PUMP; 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 (ODG) Shoulder chapter - Postoperative pain pump.

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 request for a postoperative pain pump purchase is not medically necessary. The ODG state that a postoperative pain pump is not recommended. 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 the clinical notes provided for review, there is a lack of documentation of the authorization of the repair for the right shoulder. There is also a lack of documentation of the injured worker's pain level status or the use of prescribed pain medications. Furthermore, the guidelines do not recommend the use of a postoperative pain pump. Therefore, the request for a postoperative pain pump purchase is not medically necessary.

POST-OP ELECTRICAL STIM UNIT PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines -TENS, post opeative pain (transcutaneous eectrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, post operative pain (transcutaneous electrical nerve stimulation) Page(s): 116.

Decision rationale: The request for a postoperative electrical stimulator unit purchase is not medically necessary. The California MTUS Guidelines state that a TENS for postoperative pain is recommended as a treatment option for acute postoperative in the first 30 days post surgery. It has been shown to be of lesser effect, or not at all, for other orthopedic surgical procedures. The proposed necessity of the unit should be documented upon request. A rental would be preferred over purchase during this 30 day period. In the clinical notes provided for review, there is a lack of annotation of the authorization of the proposed right shoulder rotator cuff repair. There is also a lack of documentation of the injured worker's pain level status with or without the use of pain medications. Furthermore, the guidelines do not recommend the use of the TENS postoperative for other orthopedic surgical procedures than thoracotomy pain. Therefore, the request for postoperative electrical stimulator unit purchase is not medically necessary.