

<b>Case Number:</b>	CM14-0028996		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	07/03/2013
<b>Decision Date:</b>	07/21/2014	<b>UR Denial Date:</b>	02/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2014

### 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 Occupational Medicine, 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic shoulder pain reportedly associated with an industrial injury of July 3, 2013. Thus far, the applicant has been treated with the following: Analgesic medications, attorney representation; consultation with a shoulder surgeon, who has apparently endorsed shoulder surgery; and extensive periods of time off of work. In a February 12, 2014 progress note, the claims administrator denied a request for home health services for the purposes of wound cleaning and assistance with activities of daily living, denied a pain pump, denied a DVT compression unit, denied a four-modality transcutaneous electric therapy device, and denies a request for a 30-day rental of continuous passive motion. The claims administrator somewhat erroneously stated that continuous passive motion was not recommended "for any shoulder condition," despite citing a non-MTUS ODG Guideline which specifically stated that continuous passive motion was recommended for adhesive capsulitis. The applicant was described as off of work on progress note dated March 23, 2014, at which point the applicant was reporting 7/10 shoulder, neck, mid back, and low back pain. On October 14, 2013, MRI imaging was sought of numerous body parts while the applicant was then placed off of work, on total temporary disability. On January 6, 2014, the applicant was given a shoulder corticosteroid injection and again placed off of work. In a January 24, 2014 progress note, the applicant was described as having persistent complaints of shoulder pain. It was stated that the applicant was in the process of pursuing an arthroscopic subacromial decompression and/or possible partial-thickness rotator cuff tear. Home health services were sought for the purposes of obtaining wound cleaning and assistance with activities of daily living. A pain pump was also endorsed, as was an abduction pillow and 30-day rental of a continuous passive motion device. The applicant's diagnoses list was not provided.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**RN (REGISTERED NURSE) EVALUATION FOR HOME HEALTH CARE, 4HRS/DAY X 2 WKS POST-OP FOR THE PURPOSE OF WOUND CLEANING AND ASSISTANCE WITH DAILY LIVING ACTIVITIES.:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services topic Page(s): 51.

**Decision rationale:** While this is, strictly speaking, a postoperative request as opposed to a chronic pain case, MTUS 9792.23. b2 does acknowledge that the Postsurgical Treatment Guidelines in section 9792.24.3 shall apply together with any other applicable treatment guidelines found within the MTUS during the postsurgical treatment period. In this case, since page 51 of the MTUS Chronic Pain Medical Treatment Guidelines does address the applicant's need for postoperative home health care, it is therefore invoked. As noted on page 51 of the MTUS Chronic Pain Medical Treatment Guidelines, home health services are recommended to deliver otherwise recommended medical treatment in applicants who are homebound. In this case, the applicant is apparently in the process of pursuing shoulder surgery. The applicant is diabetic, it is further noted, making wound care all the more critical. The applicant has apparently been asked to wear a sling postoperatively, which will likely limit her ability to drive and/or obtain wound care of her own accord. Therefore, the proposed two weeks of home health care is indicated. While page 51 of the MTUS Chronic Pain Medical Treatment Guidelines does not recommend provision of stand-alone housekeeping services, in this case, the applicant is concurrently receiving wound care services. Therefore, the requests are medically necessary, for all of the stated reasons.

**PAIN PUMP X 3 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) Shoulder Chapter, Postoperative Pain Pumps topic.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder Chapter, Postoperative Pain Pumps topic.

**Decision rationale:** The MTUS does not address the topic. As noted in the ODG Shoulder Chapter, Postoperative Pain Pump topic, postoperative pain pumps are "not recommended." In this case, no compelling applicant-specific rationale, narrative, commentary, or other medical evidence was attached to the request for authorization so as to offset the unfavorable guideline recommendation. Therefore, the request is likewise not medically necessary.

**DEEP VEIN THROMBOSIS (COMPRESSION 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), Hip and Pelvis Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder Chapter, Venous Thrombosis topic.

**Decision rationale:** The MTUS does not address the topic. In this case, the applicant is apparently contemplating an arthroscopic rotator cuff repair surgery. As noted in the ODG Shoulder Chapter, Venous Thrombosis topic, DVTs are very rare after an arthroscopy of the shoulder, the procedure reportedly being contemplated here. Administration of DVT prophylaxis is generally not recommended in shoulder arthroscopy procedure. In this case, attending provider did not proffer any applicant-specific rationale, narrative, commentary, and/or medical evidence which would offset the unfavorable guideline recommendation. It is not clear why the applicant would be and/or was at a heightened risk for development of DVT postoperatively. Therefore, the request is likewise not medically necessary.

**COMBO CARE 4, ELECTROTHERAPY, PURCHASE;;** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (Tens).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Galvanic Stimulation topic, Neuromuscular Electrical Stimulation topic Page(s): 117, 121.

**Decision rationale:** Combination device includes a variety of modalities, including high-voltage galvanic stimulation, neuromuscular stimulation, conventional TENS, and interferential therapy. However, multiple modalities carry unfavorable recommendations in the MTUS. Specifically, pages 117 and 121 of the MTUS Chronic Pain Medical Treatment Guidelines acknowledged that galvanic stimulation and neuromuscular stimulation, two of the modalities recommended here, are specifically not recommended for chronic pain purposes. Neuromuscular stimulation, it is further noted, is indicated only in the post stroke rehabilitative context as opposed to the chronic pain/postoperative pain context present here. Therefore, the request is likewise not medically necessary.

**CONTINUOUS PASSIVE (CPM) THERAPY X 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) Shoulder Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Third Edition, Shoulder Chapter, Adhesive Capsulitis section.

**Decision rationale:** The MTUS does not address the topic. As noted in the Third Edition ACOEM Guidelines, continuous passive motion is recommended in the management of adhesive capsulitis. In this case, however, the applicant does not apparently have adhesive capsulitis but rather apparently has a rotator cuff tear/rotator cuff tendinopathy, a condition for which continuous passive motion is not explicitly recommended. In this case, the attending provider has not furnished any compelling rationale or narrative which would support a variance from the guidelines. The attending provider has not submitted any evidence which would support the proposition that the applicant in fact carries a diagnosis of adhesive capsulitis. Therefore, the request is not medically necessary.