

<b>Case Number:</b>	CM14-0062455		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	07/13/2008
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	04/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2014

### 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, 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:

Claimant is a 48 year old female with an industrial injury dated 07/13/2008. Patient is status post right shoulder surgery as of October 2010, with 16 sessions of acupuncture, and 24 biofeedback sessions. Exam note 08/03/2013 states MRI results demonstrate tendinosis and articular surface fraying of the distal supraspinatus tendon with no evidence of a full thickness tear. In addition the patient has evidence of mild to moderate degenerative hypertrophic changes of the acromioclavicular joint and there is no evidence of a labral tear. Exam note 08/06/2013 states patient returns with increasing right shoulder pain. Exam note 03/20/2014 states the patient returned with a marked exacerbation right shoulder pain and trouble with overhead activities. Physical exam demonstrates the patient had tenderness over the AC joint, bicep tendon, and rotator cuff region. Abduction is 75, flexion 80, internal rotation 70, external rotation 70, extension 20, adduction 20, positive impingement sign and positive neer test. Patient underwent a repeat Depo-Medrol injection, and lidocaine was put forth to help with right shoulder pain. Treatment plan included a repeat arthroscopy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold Therapy Unit 7-10 days rental:** 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 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 Chapter, Continuous flow cryotherapy.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to the ODG Shoulder Chapter, continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case the requested length of time requested exceeds the recommended 7 days. Therefore the request is not medically necessary.

**Two day 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 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, Online edition, Shoulder Chapter.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of shoulder pain pumps. Per the ODG, Online edition, Shoulder Chapter, postoperative pain pumps are not recommended. Three recent moderate quality RCTs did not support the use of pain pumps. Therefore, as the guidelines do not recommend pain pumps, the request is not medically necessary.

**Companion care for 3 days:** Upheld

**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 Page(s): 51.

**Decision rationale:** According to the CA MTUS Chronic Pain Medical Treatment Guidelines, page 51, Home Health Services are recommended only for medical treatment in patients who are home-bound on a part-time or intermittent basis. Medical treatment does not include homemaker services like shopping, cleaning, laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Home health skilled nursing is recommended for wound care or IV antibiotic administration. There is no evidence in the records from 3/20/2014 that the patient is home bound or would otherwise require companion care for 3 days following routine shoulder arthroscopy. Therefore this request is not medically necessary.