

Case Number:	CM14-0063256		
Date Assigned:	07/11/2014	Date of Injury:	04/09/2013
Decision Date:	09/18/2014	UR Denial Date:	04/25/2014
Priority:	Standard	Application Received:	05/06/2014

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 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:

This 43-year-old male sustained an industrial injury on 4/9/13. The mechanism of injury was not documented. The patient underwent right carpal tunnel release on 10/24/13. The 4/7/14 treating physician report cited worsening right shoulder pain at grade 5-6/10. The patient had attended physical therapy and was now attending acupuncture for pain relief. Right shoulder range of motion was documented as flexion 100, extension 40, adduction 30, abduction 90, internal rotation 65, and external rotation 80 degrees. There was pain with range of motion. The diagnosis was mild impingement syndrome and rotator cuff tear, right shoulder. Conservative treatment had been tried and failed including medications, physical therapy, activity restrictions and corticosteroid injections. The treatment plan recommended right shoulder arthroscopy for rotator cuff and labral repair with post-operative durable medical equipment. The 4/25/14 utilization review approved the request for right shoulder arthroscopic rotator cuff and labral repair. The request for 30-day rental of a cold aqua unit was modified to a 7-day rental. The requests for post-op pain pump, continuous passive motion (CPM) machine for 60 days, and an Ultra sling were denied based on an absence of guideline support.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post operative pain pump x4 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Post-operative pain pump.

Decision rationale: The California MTUS guidelines are silent regarding this device. The Official Disability Guidelines state that post-operative pain pumps are not recommended. Guidelines state 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. Three recent moderate quality randomized controlled trials did not support the use of pain pumps. Given the absence of guideline support for the use of post-operative pain pumps, this request is not medically necessary.

Cold Aqua unit 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.

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 California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. The 4/25/14 utilization review decision recommended partial certification of this cold therapy device for 7-day use. There is no compelling reason to support the medical necessity of a cold therapy unit beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.

CPM Machine x 60 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.

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 passive motion (CPM).

Decision rationale: The California MTUS are silent regarding continuous passive motion (CPM) units. The Official Disability Guidelines do not recommend CPM units for rotator cuff problems. These units are recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Guideline criteria have not been met. Arthroscopic rotator cuff and labral repair was planned. There is no clinical evidence suggestive of adhesive capsulitis. There is no compelling reason to support the medical necessity of this unit in the absence of guideline support. Therefore, this request is not medically necessary.

Post Operative DME: Ultra sling: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling.

Decision rationale: The California MTUS are silent regarding post-op abduction pillow slings, but support standard slings for post-op use. The Official Disability Guidelines state that post-operative abduction pillow slings are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. Arthroscopic rotator cuff and labral repair are planned. Guidelines generally support a standard sling for post-operative use. There is no compelling reason to support the medical necessity of a specialized abduction sling over a standard sling. Therefore, this request is not medically necessary.