MAXIMUS Federal Services

Case Number:	CM14-0069012		
Date Assigned:	08/04/2014	Date of Injury:	07/01/2009
Decision Date:	09/25/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	05/14/2014

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 Internal Medicine and is licensed to practice in Maryland. 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 employee was a 50 year old female with a date of injury on 07/01/09. The mechanism of injury was elbow and hand injury on the left side while pulling a cart with files. Her initial treatment included cortisone injections to left elbow, left elbow surgery in 2010, post-operative physical therapy, followed by 2 more arthroscopic surgeries to left elbow. Her symptoms included pain in the left shoulder, left elbow pain radiating into the inner arm accompanied by numbness and tingling in the little finger, ring finger and middle finger. She also had pain in right elbow and right hand due to compensating for the left upper extremity. Her medications included Hydrochlorothiazide, Vicodin, Tramadol, Naprosyn, Prilosec, Xanax, topical Ketoprofen, topical Gabapentin and topical Tramadol. Prior evaluations included an EMG/NCV of upper extremities on 01/22/14 that revealed minimal bilateral carpal tunnel syndrome and bilateral chronic active C6 radiculopathy, left greater than right, an MRI of cervical spine on 01/24/14 that showed straightening of cervical spine and 2-mm disc bulges at C3-4, C4-5 and C5-6 and an MRI of left shoulder on 01/31/14 that was significant for effusion, arthrosis of AC joint, anterior and posterior capsulitis, extrinsic impingement on the supraspinatus and overlying deltoid, supraspinatus tendon partial versus full thickness tear, fluid in the subscapularis bursa and biceps tendon sheath and SLAP tear with anterior labral tear. Her notes from 03/18/14 were reviewed. She reported mild right shoulder pain, moderate bilateral wrist pain, moderate left elbow pain and severe left shoulder pain. She had limited range of motion of bilateral shoulders, left more than right, positive impingement test, positive Neer test, positive Hawkin's test and positive adduction test on the left. Her diagnoses included left shoulder impingement syndrome with posttraumatic arthrosis of the acromioclavicular joint, rule out rotator cuff tear. Also evaluated was a venous thromboembolism risk assessment form that had moderate risk for VTE with recommendation to use elastic stockings, medication and/or use of an intermittent

pneumatic compression device. The operative report also was reviewed. She had left shoulder arthroscopic extensive distal claviculectomy, arthroscopic extensive subacromial decompression, diagnostic arthroscopy and placement of pain pump. It was noted that X-Force leg compression device to prevent blood clots needed to be used and a pain pump was used for 72 hours for the painful operation. She was asked to use CPM for 30 days and Q tech recovery system with hot and cold therapies for 6-8 hours for 35 days after surgery. An ON-Q programmable pain pump has been ordered for patient to use with their rehabilitation program for 3-5 days following surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Optimum Home Rehab Kit: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg.

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

Decision rationale: The employee had left shoulder pain and had left shoulder arthroscopic extensive distal claviculectomy, arthroscopic extensive subacromial decompression, diagnostic arthroscopy and placement of pain pump. She had a preoperative diagnosis of partial tear of rotator cuff with impingement syndrome and arthrosis of AC joint. The request was Optimum home rehab kit. According to Official Disability Guidelines, home exercise kits are recommended where home exercise programs are recommended and where active self-directed home physical therapy is recommended. Exercises are recommended after shoulder surgery for early mobilization. Hence the Optimum home rehab kit is medically necessary and appropriate.

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)-TWC.

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 employee had left shoulder pain and had left shoulder arthroscopic extensive distal claviculectomy, arthroscopic extensive subacromial decompression, diagnostic arthroscopy and placement of pain pump. She had a preoperative diagnosis of partial tear of rotator cuff with impingement syndrome and arthrosis of AC joint. The request was for pain pump purchase. According to Official Disability guidelines, postoperative pain pump is not recommended given 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. There were no exceptional conditions noted in the medical records that will preclude treatment of pain with conventional methods. Hence the request for pain pump is not medically necessary or appropriate.

CPM Rental for 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 Continuous Passive.

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

Decision rationale: The employee had left shoulder pain and had left shoulder arthroscopic extensive distal claviculectomy, arthroscopic extensive subacromial decompression, diagnostic arthroscopy and placement of pain pump. She had a preoperative diagnosis of partial tear of rotator cuff with impingement syndrome and arthrosis of AC joint. The request was for CPM rental for 30 days and pad for CPM. According to Official Disability guidelines, CPM is not recommended postoperatively after shoulder surgery except with adhesive capsulitis. The employee didn't have a diagnosis of adhesive capsulitis. Hence the request for CPM rental and pad for CPM machine are not medically necessary or appropriate.

Pad for CPM Machine: 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 Continuous Passive Motion.

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

Decision rationale: The employee had left shoulder pain and had left shoulder arthroscopic extensive distal claviculectomy, arthroscopic extensive subacromial decompression, diagnostic arthroscopy and placement of pain pump. She had a preoperative diagnosis of partial tear of rotator cuff with impingement syndrome and arthrosis of AC joint. The request was for CPM rental for 30 days and pad for CPM. According to Official Disability guidelines, CPM is not recommended postoperatively after shoulder surgery except with adhesive capsulitis. The employee didn't have a diagnosis of adhesive capsulitis. Hence the request for CPM rental and pad for CPM machine are not medically necessary or appropriate.

Q-Tech Cold Therapy Recovery System Rental with Wrap #35: 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)-TWC.

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 employee had left shoulder pain and had left shoulder arthroscopic extensive distal claviculectomy, arthroscopic extensive subacromial decompression, diagnostic arthroscopy and placement of pain pump. She had a preoperative diagnosis of impingement syndrome and arthrosis of AC joint. The request was for Q tech cold therapy #35. According to Official Disability Guidelines, cryotherapy is recommended as an option after shoulder surgery, for up to 7 days including home use. The surgeon documented that the Q tech cold therapy was for 6-8 hours for 30 days. Since the duration requested is beyond the guidelines recommendation, the request is not medically necessary and appropriate.

Pad for Water Circulating Heat Unit: 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) - TWC, Shoulder Chapter.

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

Decision rationale: The employee had left shoulder pain and had left shoulder arthroscopic extensive distal claviculectomy, arthroscopic extensive subacromial decompression, diagnostic arthroscopy and placement of pain pump. She had a preoperative diagnosis of impingement syndrome and arthrosis of AC joint. The request was for pad for water circulating heat unit. According to Official Disability Guidelines, cryotherapy is recommended as an option after shoulder surgery, for up to 7 days including home use. The surgeon documented that the Q tech cold therapy was for 6-8 hours for 30 days. The pad for water circulating heat unit was to be used with the Q tech system. Since the duration requested is beyond the guidelines recommendation, the request is not medically necessary and appropriate.

Non- Segmental Pneumatic Appliance for use with Pneumatic Compressor: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, Hand, Vasopneumatic Device.

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

Decision rationale: The employee had left shoulder pain and had shoulder arthroscopic surgery. The request was for Non- Segmental Pneumatic Appliance for use with Pneumatic Compressor. According to the medical records available for review, she was at moderate risk for VTE and so

the surgeon requested pneumatic compression for prophylaxis. According to Official disability guidelines, compression garments are generally not recommended in the shoulder due to the low incidence of VTE after upper extremity surgeries. But the final decision to consider thromboprophylaxis exists with the operating surgeon. Since the employee's surgeon did a risk evaluation for VTE and thought she needed prophylaxis based on the moderate risk, the request for non-segmental pneumatic appliance for use with pneumatic compressor is medically necessary and appropriate.