MAXIMUS Federal Services

Case Number:	CM14-0074418		
Date Assigned:	07/16/2014	Date of Injury:	01/10/2007
Decision Date:	02/25/2015	UR Denial Date:	04/13/2014
Priority:	Standard	Application Received:	05/22/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Physical Medicine & Rehabn

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 patient is a 64 year old female with an injury date of 01/10/07. Based on the 03/19/14 progress report provided by treating physician, the patient is 2 weeks status post left shoulder arthroscopic subacromial decompression, with moderate pain to the shoulder, neck and back. Patient is using her CPM machine up to 70 degrees. Physical examination to the shoulders on 03/19/14 revealed range of motion is still decreased, especially on flexion 70, and abduction 60 degrees bilaterally. The punctures are healed and sutures were removed. Patient has not started therapy, yet. Medications include Norco, Xanax and Prilosec. The patient is doing well and remains temporarily totally disabled.Operative Report 03/07/14Diagnosis: left shoulder rotator cuff tear plus adhesive capsulitis plus posttraumatic arthrosis of the AC jointProcedure: - left shoulder arthroscopic rotator cuff repair- arthroscopic decompression- placement of pain pumpDiagnosis 03/19/14- left shoulder rotator cuff tear- left shoulder post traumatic arthrosis of the AC joint- right shoulder rotator cuff tear- right shoulder post traumatic arthrosis at the AC joint- severe shoulder pain with limited range of motion bilaterally, industrial- status post ACDF at C5-6 and C6-7, industrial- status post lumbar L4 through S1 decompression fusion, industrial- anxiety and depression, industrial- insomnia, industrialThe utilization review determination being challenged is dated 04/13/14.Treatment reports were provided from 06/24/13 - 03/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Q-Tech DVT prevention system x 35 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG(The 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 Chapter , Vein thrombosis.

Decision rationale: The patient is two weeks status post left shoulder arthroscopic subacromial decompression; and presents with moderate pain to the shoulder, neck and back. The request is for Q-Tech DVT prevention system x 35 days. Patient is also status post ACDF at C5-6 and C6-7; and status post lumbar L4 through S1 decompression fusion, dates unspecified. Patient's diagnosis on 03/19/14 included left shoulder rotator cuff tear and bilateral shoulder post traumatic arthrosis of the AC joint. Physical examination to the shoulders on 03/19/14 revealed range of motion is still decreased, especially on flexion 70, and abduction 60 degrees bilaterally. The punctures are healed and sutures were removed. Patient has not started therapy, yet. Medications include Norco, Xanax and Prilosec. The patient is doing well and remains temporarily totally disabled.The MTUS and ACOEM Guidelines do not address DVT Prophylaxis unit. However, ODG Guidelines do address DVT Prophylaxis unit. ODG-TWC, Shoulder Chapter states: "Vein thrombosis: "Recommend monitoring risk of perioperative thromboembolic complications in both the acute and subacute postoperative periods for possible treatment, and identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures such as consideration for anticoagulation therapy. Upper extremity DVT is much less studied compared to lower extremity DVT and the diagnostic and therapeutic modalities still have substantial areas that need to be studied."Treater has not provided reason for the request. It appears the request was for post-operative use following left shoulder arthroscopic subacromial decompression surgery. Treater has not stated risk of perioperative thromboembolic complication, nor has he identified the patient to be at high risk of developing venous thrombosis, as required by guidelines. Furthermore, upper extremity DVT still has substantial areas that need to be studied when compared to lower extremity DVT. Following shoulder surgery, there is unlikely any period of immobility for which DVT prophylaxis would be needed. The request does not meet guideline indications. Therefore, the Q-Tech DVT prevention system is not medically necessary.

Q-Tech cold therapy recovery system with wrap x 35 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation ODG(The 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 Chapter, under Continuous-flow Cryotherapy.

Decision rationale: The patient is 2 weeks status post left shoulder arthroscopic subacromial decompression; and presents with moderate pain to the shoulder, neck and back. The request is for Q-Tech cold therapy recovery system with wrap x 35 days. Patient is also status post ACDF at C5-6 and C6-7; and status post lumbar L4 through S1 decompression fusion, dates unspecified. Patient's diagnosis on 03/19/14 included left shoulder rotator cuff tear and bilateral shoulder post traumatic arthrosis of the AC joint. Physical examination to the shoulders on 03/19/14 revealed range of motion is still decreased, especially on flexion 70, and abduction 60 degrees bilaterally. The punctures are healed and sutures were removed. Patient has not started therapy, yet. Medications include Norco, Xanax and Prilosec. The patient is doing well and remains temporarily totally disabled. The MTUS and ACOEM Guidelines do not discuss water therapy units. ODG Guidelines Shoulder Chapter, under Continuous-flow Cryotherapy states, "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated".Treater has not provided reason for the request. It appears the request was for post-operative use following left shoulder arthroscopic subacromial decompression surgery. Per request, the intended duration of use is 35 days. However, the ODG Guidelines recommends the duration of postoperative use of continuous-flow cryotherapy to be 7 days. The patient is beyond the postoperative recovery duration of 7 days, for which unit would be indicated. Therefore, the request is not medically necessary.

Shoulder CPM with pads x 30 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG(The Official Disability Guidelines)-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 (Acute & Chronic) Chapter, under Continuous passive motion (CPM).

Decision rationale: The patient is 2 weeks status post left shoulder arthroscopic subacromial decompression; and presents with moderate pain to the shoulder, neck and back. The request is for shoulder CPM with pads x 30 days. Patient is status post ACDF at C5-6 and C6-7; and status post lumbar L4 through S1 decompression fusion, dates unspecified. Patient's diagnosis on 03/19/14 included left shoulder rotator cuff tear and bilateral shoulder post traumatic arthrosis of the AC joint. Physical examination to the shoulders on 03/19/14 revealed range of motion is still decreased, especially on flexion 70, and abduction 60 degrees bilaterally. The punctures are healed and sutures were removed. Patient has not started therapy, yet. Medications include Norco, Xanax and Prilosec. The patient is doing well and remains temporarily totally disabled. The ACOEM and MTUS do not discuss continuous passive motion devices.ODG-TWC, Shoulder (Acute & Chronic) Chapter, under Continuous passive motion (CPM) states: "Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. See the Knee Chapter for more information on continuous passive motion devices. Rotator cuff tears: Not recommended after shoulder surgery

or for nonsurgical treatment."Treater has not provided reason for the request. It appears the request is for post-operative use following left shoulder arthroscopic subacromial decompression surgery. The patient's Operative Report diagnosis dated 03/07/14 was left shoulder rotator cuff tear plus adhesive capsulitis. Though ODG recommends CPM for adhesive capsulitis, guidelines do not support CPM for rotator cuff problems. Furthermore, the request for 30 days exceeds the 20 day recommendation. Therefore, the request is not medically necessary.

Programmable pain pump: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG(The Official Disability Guidelines) TWC; ODG Treatment; Intergrated treatment/Disability Duration Guidelines, Shoulder, 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 Chapter under Pain Pumps, Postoperative.

Decision rationale: The patient is 2 weeks status post left shoulder arthroscopic subacromial decompression; and presents with moderate pain to the shoulder, neck and back. The request is for programmable pain pump. Patient is status post ACDF at C5-6 and C6-7; and status post lumbar L4 through S1 decompression fusion, dates unspecified. Patient's diagnosis on 03/19/14 included left shoulder rotator cuff tear and bilateral shoulder post traumatic arthrosis of the AC joint. Physical examination to the shoulders on 03/19/14 revealed range of motion is still decreased, especially on flexion 70, and abduction 60 degrees bilaterally. The punctures are healed and sutures were removed. Patient has not started therapy, yet. Medications include Norco, Xanax and Prilosec. The patient is doing well and remains temporarily totally disabled. MTUS and ACOEM Guidelines do not address this request.However, ODG-TWC, Shoulder Chapter under Pain Pumps, Postoperative states: "Not recommended. Three recent moderate quality RCTs did not support the use of pain pumps. Before these studies, evidence supporting the use of ambulatory pain pumps existed primarily in the form of small case series, and poorly designed, randomized, control studies with small populations. This study concluded that infusion pumps did not significantly reduce pain levels."Treater has not provided reason for the request. It appears the request is for post-operative use following left shoulder arthroscopic subacromial decompression surgery. Based on Operative Report dated 03/07/14, the pain pump has already been placed. However, ODG Guidelines do not provide support for the use of pain pumps use following shoulder surgery. Therefore, the request is not medically necessary.

Optimum home rehab kit: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

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, Exercise Kit.

Decision rationale: The patient is 2 weeks status post left shoulder arthroscopic subacromial decompression; and presents with moderate pain to the shoulder, neck and back. The request is for Optimum home rehab kit. Patient is status post ACDF at C5-6 and C6-7; and status post lumbar L4 through S1 decompression fusion, dates unspecified. Patient's diagnosis on 03/19/14 included left shoulder rotator cuff tear and bilateral shoulder post traumatic arthrosis of the AC joint. Physical examination to the shoulders on 03/19/14 revealed range of motion is still decreased, especially on flexion 70, and abduction 60 degrees bilaterally. The punctures are healed and sutures were removed. Patient has not started therapy, yet. Medications include Norco, Xanax and Prilosec. The patient is doing well and remains temporarily totally disabled.ODG-TWC, Shoulder Chapter under Exercise Kit states: "Recommended. See Exercises, where home exercise programs are recommended; & Physical therapy, where active self-directed home physical therapy is recommended. In this RCT a specific shoulder home exercise program resulted in 69% good outcomes versus 24% in the sham exercise group, and 20% of patients in the specific exercise group subsequently chose to undergo surgery versus 63% in the control group. Shoulder disorders may lead to joint stiffness more often than other joint disorders. Therapeutic exercise, including strengthening, should start as soon as it can be done without aggravating symptoms."Treater has not provided reason for the request. It appears the request is for post-operative use following left shoulder arthroscopic subacromial decompression surgery. In this case, the patient still presents with shoulder pain, and will be attending physical therapy. There is no mention that patient has had prior usage of exercise kit for the shoulder. ODG guidelines recommend exercise kit for the shoulder. Therefore, the request is medically necessary.