MAXIMUS Federal Services

Case Number:	CM15-0100889		
Date Assigned:	06/03/2015	Date of Injury:	08/22/2014
Decision Date:	07/01/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	05/26/2015

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, Indiana, Oregon
Certification(s)/Specialty: Orthopedic Surgery

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 injured worker is a 40 year old female, who sustained an industrial injury on 8/22/14. She reported initial complaints of a left shoulder injury. The injured worker was diagnosed as having bicipital tenosynovitis; impingement syndrome. Treatment to date has included physical therapy; chiropractic care; medications. Diagnostics included MRI left shoulder (2/19/15). Currently, the PR-2 notes dated 4/29/15 indicated the injured worker complains of intractable left shoulder pain due to her work injury. The orthopedic examination of the left shoulder notes tenderness to the anterior shoulder region, inclusive of the subacromial space, inclusive of the acromioclavicular joint. Spasms and swelling with no trapezial or paraspinal muscle tightness is noted. Range of motion indicates flexion 145 degrees, extension 40 degrees, abduction 135, adduction 10, external rotation 67 and internal rotation 20. Strength testing: deltoid 5/5, negative external rotation lag sign (infraspinatus), negative horn blower sign (teres minor). Sensation: unremarkable. Provocative testing: positive Neer impingement sign, positive Hawkin's impingement sign, positive cross-chest, positive AC joint compression test, positive Yergason's test, positive dynamic compression shear test, negative O'Brien's test, negative Speeds test, negative crepitation on circumduction. Stability tests: negative apprehension test, negative sulcus sign, negative relocation/release test, negative posterior jerk sign. Vascular: good baseline peripheral pulses, no peripheral edema. A MRI of the left shoulder dated 2/19/15 is documented in these notes as: Flat, low-lying acromion combined with degenerative changes in the acromioclavicular joint causing narrowing of the supraspinatus outlet which may predispose to impingement; supraspinatus tendinosis and infraspinatus tendinosis. The provider has requested

a CPM (continuous passive motion) rental 21 days; Cold therapy unit purchases and pain pump purchase for the authorized left shoulder arthroscopic acromioplasty with distal claviculectomy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Services: Cold therapy unit purchase: Upheld

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for up to of 7 days. The DME definition in the same section states that DME is durable and could normally be rented and used by successive patients. Based on the above, the request for the purchase is not medically necessary.

Associated Surgical Services: 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: Shoulder chapter (acute & chronic) - Postoperative pain pumps.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder and Other Medical Treatment Guidelines Ciccone WJ 2nd, Busey TD, Weinstein DM, Walden DL, Elias JJ. Assessment of pain relief provided by interscalene regional block and infusion pump after arthroscopic shoulder surgery. Arthroscopy. 2008 Jan; 24 (1): 14-9.

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder pain pumps. Per the Official Disability Guidelines, Online edition, Shoulder Chapter, regarding postoperative pain pumps, "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, controlled studies with small populations." In addition, there are concerns regarding chondrolysis in the peer reviewed literature with pain pumps in the shoulder postoperatively. As the guidelines and peer, reviewed literature does not recommend pain pumps, the determination is not medically necessary.

Associated Surgical Services: CPM (continuous passive motion) rental, 21 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: Shoulder chapter - 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.

Decision rationale: CA MTUS/ACOEM guidelines are silent on the issue of CPM machine. According to the Official Disability Guidelines, Shoulder Chapter, Continuous passive motion (CPM), CPM is recommended for patients with adhesive capsulitis but not with patients with rotator cuff pathology primarily. With regards to adhesive capsulitis it is recommended for 4 weeks. As there is no evidence preoperatively of adhesive capsulitis in the exam note 4/29/15, the determination is not medically necessary.