

Case Number:	CM15-0142007		
Date Assigned:	07/31/2015	Date of Injury:	04/08/2014
Decision Date:	09/03/2015	UR Denial Date:	07/15/2015
Priority:	Standard	Application Received:	07/21/2015

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: Minnesota, Florida

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 35 year old with an industrial injury date 04-08-2013-04-08-2014 (cumulative trauma). The injury is documented as occurring while doing repetitive work at a laundry where she was lifting 50 pounds. She experienced pain in her cervical spine. Her diagnoses included bilateral impingement syndrome, bilateral lateral epicondylitis and bilateral carpal tunnel syndrome. Prior treatment included activity modification, medications and therapy. She presented on 06-22-2015 with complaints of shoulder pain. She continued using pain medications, with modified activity level and therapy. She describes the pain as moderate to severe with profound limitations. The provider documents the condition is not proceeding as expected and patient is a surgical candidate. "Therapeutic goals are not being met at this time." Physical exam noted tenderness to the anterior shoulder region, inclusive of the subacromial space and inclusive of the acromioclavicular joint. Trapezial tightness was noted and range of motion was decreased in all ranges. The following tests were positive Neer impingement sign, Hawkins impingement sign, cross-chest test, AC joint compression test, Speed's test and dynamic compression shear test. MRI dated 11-14-2014 showed osteoarthritis of acromioclavicular joint, supraspinatus tendinosis, infraspinatus tendinosis and subacromial-sub deltoid bursitis. The formal report is in the submitted records. The treatment plan included surgical request for left shoulder, arthroscopic acromioplasty with distal claviclectomy with associated surgical services, wrist splint, medications and off work until next evaluation. The treatment request for the following was authorized: Left shoulder arthroscopic acromioplasty with distal claviclectomy. Associated surgical service: Vicodin 5/300 mg quantity 40.

Associated surgical service: abduction brace. Post-operative physical therapy time 12 sessions. The treatment requests for review are as follows: Associated surgical service: cold therapy unit purchase. Associated surgical service: pain pump purchase. Associated surgical service: 21 day CPM rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: 21 day CPM rental: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Continuous Passive Motion.

Decision rationale: California MTUS guidelines are silent on this issue. ODG guidelines are therefore used. Continuous passive motion for the shoulder is recommended if there is evidence of adhesive capsulitis. In this case, the documentation provided does not indicate the presence of adhesive capsulitis. Therefore, the request for 21-day CPM rental is not supported by evidence-based guidelines and the medical necessity of the request has not been substantiated.

Associated surgical service: cold therapy unit purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Continuous flow cryotherapy.

Decision rationale: California MTUS guidelines are silent on this issue. ODG guidelines are therefore used. ODG guidelines recommend continuous-flow cryotherapy for 7 days after shoulder surgery. It reduces pain, inflammation, swelling, and the need for narcotics after surgery. Use beyond 7 days is not recommended. The request as stated is for a cold therapy unit purchase, which is not supported by guidelines. As such, the medical necessity of the request has not been substantiated.

Associated surgical service: pain pump purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Postoperative pain pump.

Decision rationale: California MTUS guidelines are also silent on this issue. ODG guidelines do not recommend the use of pain pumps after shoulder surgery. 3 randomized controlled trials did not support the use of pain pumps. A small case series of 10 patients concluded that the use of pain pump catheters appeared highly associated with the postoperative complication of chondrolysis. A pain pump purchase is therefore not supported and the medical necessity of the request has not been substantiated.