

Case Number:	CM14-0131841		
Date Assigned:	09/19/2014	Date of Injury:	04/20/2012
Decision Date:	11/12/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/18/2014

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 Orthopaedic 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 52-year-old male sustained an industrial injury on 4/20/12. Injury occurred when he was attempting to descend a ladder through a roof window and his right shoulder gave out. He fell a distance and was left hanging by his left shoulder which he felt subluxation. He underwent right shoulder SLAP repair in on 7/19/12, and anterior cervical discectomy and fusion C4 through C7 in September 2013. The 3/5/14 right shoulder MRI impression documented mild to moderate acromioclavicular joint degenerative changes, glenohumeral joint osteoarthritis changes, and mild supraspinatus tendinopathy. There was no evidence of rotator cuff tear or labral pathology. There was no evidence of subacromial/subdeltoid bursal fluid collection. The biceps tendon was within the bicipital groove and its attachment to the supraglenoid tubercle was unremarkable. The 6/24/14 treating physician report cited severe left shoulder pain and instability. There was on-going right shoulder pain. Bilateral shoulder passive and active range of motion was limited to 90 degrees of forward flexion and abduction with severe end range pain. There did not appear to be a mechanical block. Internal/external rotation was limited to 60 degrees bilaterally. There was normal elbow and wrist motor strength. There was significant tenderness over the left subacromial space and with gentle internal/external rotation and circumduction of the left shoulder. There was palpation left shoulder crepitus with motion. Left shoulder x-rays documented some inferior acromial spurring. The diagnosis included left shoulder glenohumeral arthrosis and subacromial impingement syndrome. The patient had failed prolonged conservative treatment for the left shoulder. Authorization was requested for left shoulder arthroscopy with acromioplasty, Mumford procedure, debridement, removal of loose bodies, and possible glenohumeral chondroplasties. The 7/23/14 utilization review denied the associated surgical requests for post-op continuous passive motion device rental and pain pump as there was no

guideline support for use and no medical basis for treatment outside of the guidelines. The request for cold therapy unit rental for 30 days was modified to 7 days consistent with guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shoulder CPM X 30 day rental post op: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, (www.odgtwc.com/odgtwc/shoulder.htm)

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 recommend continuous passive motion as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Guideline criteria have been met. There is clinical evidence suggestive of adhesive capsulitis. Post-operative use of this device for 30 days is generally consistent with guidelines. Therefore, this request is medically necessary.

Cold therapy unit x 30 days post op: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, (www.odgtwc.com/odgtwc/shoulder.htm)

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 7/23/14 utilization review decision recommended partial certification of this cold therapy device for 7-day use. There is no compelling reason in the records reviewed to support the medical necessity of a cold device beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.

Shoulder pain pump: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, (www.odgtwc.com/odgtwc/shoulder.htm)

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 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.