

Case Number:	CM14-0091669		
Date Assigned:	07/25/2014	Date of Injury:	01/10/2007
Decision Date:	10/21/2014	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	06/17/2014

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 Physical Medicine & Rehabilitation 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:

The injured worker is a 64-year-old female who reported injury on 01/10/2007. The mechanism of injury was not submitted for review. The injured worker has diagnoses of left shoulder rotator cuff tear, left shoulder posttraumatic arthrosis of the AC joint, right shoulder rotator cuff tear, right shoulder posttraumatic arthrosis of the AC joint, severe shoulder pain with limited range of motion bilaterally, status post ACDF at C5-6 and C6-7, status post lumbar L4-S1 decompression fusion, and anxiety and depression. Past medical treatment consists of surgery, physical therapy, aquatic therapy and medication therapy. Medications include Norco, Prilosec, and Xanax. In 03/2014, the injured worker underwent left shoulder arthroscopic subacromial decompression. On 03/19/2014, the injured worker complained of neck and mid back pain. It was noted that the injured worker had a shoulder flexion of 70 degrees bilaterally, abduction of 60 degrees bilaterally, extension of 30 degrees bilaterally, internal rotation of 50 degrees bilaterally, and external rotation of 50 degrees bilaterally. The injured worker had 1/4 pain bilaterally with this range of motion. The treatment plan for the injured worker was to have access to a [REDACTED] DVT prevention system, [REDACTED] cold therapy recovery system, CPM machine, programmable pain pump, and optimum home rehab kit. The rationale and request for authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

[REDACTED] 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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Venous thrombosis [REDACTED] DVT prevention.

Decision rationale: According to the Official Disability Guidelines, minor injuries in the leg are associated with greater risk of venous thrombosis. The relative risk for venous thrombosis is 3-fold greater following minor injury, especially if injury occurs in the 4 weeks prior to thrombosis, is located in the leg, and involves multiple injuries or rupture of muscle or ligament. Risk factors for venous thrombosis include immobility, surgery, and prothrombotic genetic variants. Patients, who are at high risk for venothromboembolism, should be considered for anticoagulation therapy during post hospitalization. Current evidence suggests it is needed in patients undergoing many orthopedic, general, and cancer surgery procedures that should be given for at least 7 to 10 days. It was noted in the submitted documentation that the injured worker underwent left shoulder arthroscopy subacromial decompression in beginning of 03/2014. However, the guidelines indicate that the use of a DVT machine should be used within at least the first 7 to 10 days post-surgery. Given the above, the injured worker is not within the Official Disability Guidelines criteria. As such, the request is not medically necessary.

[REDACTED] Cold Therapy Recovery System with Wrap x 35 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Game Ready accelerated recovery system.

Decision rationale: According to the Official Disability Guidelines, cold compression therapy (game ready accelerator recovery system), is not recommended in the shoulder, as there are no published studies. It may be an option for other body parts to include the knees. Game ready device provides both active, continuous cold and intermittent, pneumatic compression to the postoperative joint. There has been an RCT underway since 2008 to evaluate and compare clinical postoperative outcomes for patients using an active cooling and compression device and those using ice packs and elastic wrap after acromioplasty or arthroscopic rotator cuff repair, but the results are not available. Given the Official Disability Guidelines, the request would not be recommended. As such, the request is not medically necessary.

Shoulder CPM with pads x 30 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG

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: According to Official Disability Guidelines, a CPM machine is not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. The guidelines also state that it is not recommended after shoulder surgery or for nonsurgical treatment. An AHRQ comparative effectiveness review concluded that evidence on the comparative effectiveness on the harms of various operative and non-operative treatments for rotator cuff tears is limited and inconclusive. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for difference in function or pain, and one study found no difference in range of motion or strength. Given that Official Disability Guidelines do not recommend the use of a CPM machine, the request is not medically necessary.

Programmable Pain Pump Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG

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: According to the Official Disability Guidelines, postoperative pain pumps are not recommended. Three recent moderate quality RTCs 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. Much of the available evidence has involved assessing efficacy following orthopedic surgery, specifically, shoulder and knee procedures. A surgeon will insert a temporary, easily removable catheter into the shoulder joint that is connected to an automatic pump filled with anesthetic solution. This pain pump was intended to help considerably with postoperative discomfort, and is removed by the patient or their family 2 or 3 days after surgery. 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. Given the above and official Disability Guidelines do not recommend the use of pain pumps, the request is not medically necessary.

Optimum Home Rehab Kit Purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Exercises.

Decision rationale: The California MTUS Guidelines state there is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs and do not include exercise. There is no sufficient evidence to support the

recommendation of any particular exercise regimen over any other exercise program. The Official Disability Guidelines also state that a home exercise kit is recommended. A specific shoulder home exercise program would locate 69% good outcome versus 24% in the same exercise group, and 20% in patients in this specific exercise group subsequently chose to undergo surgery versus 63% of the controlled group. The injured worker had been provided prior physical therapy and should be well versed in the home exercise program to address any deficits. Furthermore, it is not indicated or specified in the submitted request as to which shoulder the kit would be used on. It is documented in the submitted report the injured worker had no complaints of shoulder pain. Given the above, the request for the purchase of a home exercise kit is not medically necessary.