

Case Number:	CM14-0215644		
Date Assigned:	01/05/2015	Date of Injury:	07/09/2014
Decision Date:	02/28/2015	UR Denial Date:	12/16/2014
Priority:	Standard	Application Received:	12/23/2014

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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 47-year-old man who sustained a work related injury on July 9, 2014. Subsequently, he developed left shoulder pain. According to a progress report dated October 10, 2014, the patient stated that his symptoms have remained the same since his last visit. he complained of intense sharp pain in his shoulders that radiated into both arms and limited range of motion. The patient rated the level of his pain as a 10/10. The patient has a known rotator cuff tear in the right shoulder for which surgery has been recommended and already authorized. The patient is still awaiting certification for the MRI of his left shoulder. The patient exhibited bilateral shoulder pain with overhead activities or when sleeping on his shoulders.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shoulder CPM machine/kit for rental or 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 (ODG), TWC Shoulder procedure summary, CPM, Blue Cross of California medical policy # DME.00019, Continuous Passive Motion Devices

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Guidelines (ODG) Continuous passive motion (CPM).

Decision rationale: According to ODG Guidelines, continuous passive motion is 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. (Raab, 1996) (BlueCross BlueShield, 2005) An AHRQ Comparative Effectiveness Review concluded that evidence on the comparative effectiveness and the harms of various operative and nonoperative 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 no difference in function or pain, and one study found no difference in range of motion or strength. (Seida, 2010) Adhesive capsulitis: According to this RCT, CPM treatment for adhesive capsulitis provides better response in pain reduction than conventional physical therapy. The CPM group received CPM treatments for 1 h once a day for 20 days during a period of 4 weeks. The PT group had a daily physical therapy treatment including active stretching and pendulum exercises for 1 h once a day for 20 days during a period of 4 weeks. All patients in both groups were also instructed in a standardized home exercise program consisting of passive range of motion and pendulum exercises to be performed every day. In both groups, statistically significant improvements were detected in all outcome measures compared with baseline. Pain reduction, however, evaluated with respect to pain at rest, at movement and at night was better in CPM group. In addition the CPM group showed better shoulder pain index scores than the PT group. (Dundar, 2009) Because adhesive capsulitis involves fibrotic changes to the capsuloligamentous structures, continuous passive motion or dynamic splinting are thought to help elongate collagen fibers. (Page, 2010) >That is no rationale behind the use of shoulder CPM. There is no documentation that the patient is suffering from left shoulder adhesive capsulitis. Therefore, the request for Retrospective Shoulder CPM machine/kit for rental or purchase is not medically necessary.

Shoulder pain pump for rental or 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 (ODG), TWC, Shoulder procedure summary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder, <http://www.worklossdatainstitute.verioiponly.com/odgtwc/shoulder.htm#Postoperativepainpump>

Decision rationale: According to ODG guidelines, post op pain pump is 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. 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. There is no evidence to support the need of cold therapy in this patient. There is not enough documentation relevant to the patient work injury to determine the medical necessity for cold therapy. There is no controlled studies supporting the use of hot/cold in shoulder pain beyond a short period of time after surgery. The provider have the document the timing and the duration of shoulder cold therapy. Cold therapy is not indicated for chronic pain. Therefore, the request for Shoulder pain pump for rental or purchase is not medically necessary.