

Case Number:	CM13-0010927		
Date Assigned:	11/22/2013	Date of Injury:	01/01/2006
Decision Date:	12/12/2014	UR Denial Date:	08/02/2013
Priority:	Standard	Application Received:	08/14/2013

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 Internal Medicine 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 patient is a 56 year old female who was injured on 01/01/2006 due to repetitive activities that were work related. The patient underwent diagnostic inoperative arthroscopy of the left shoulder, partial synovectomy, Mumford procedure, acromioplasty; chondroplasty of the humeral head on 09/19/2013. Progress report dated 07/24/2013 states the patient complained of bilateral shoulder pain and stiffness, left greater than right. She reported physical therapy was helping temporarily and would like to proceed with surgery. She also reported acupuncture has helped her in the past with benefit of relieving her symptoms. On exam, her left shoulder range of motion revealed abduction at 100; adduction at 40; flexion as 120; and extension at 45. She had positive impingement sign and apprehension sign. There was positive impingement sign in the right shoulder. She is diagnosed with left shoulder labral tear, left shoulder rotator cuff tear; muscular spasm of left parascapular muscles; and right shoulder impingement syndrome. The patient was recommended for surgery of the right shoulder, pain pump for 4 days, cold unit for 14 days, IF unit for 14 days, CPM unit for 14 days and ultra sling; post-op physical therapy 2x4 to the left shoulder to begin 4 weeks post surgery. She was seen on 10/23/2013 noting physical therapy has been helpful and she is doing home exercises with the CPM machine. She noted her pain is tolerable and had completed 7/8 physical therapy sessions. Prior utilization review dated 08/02/2013 states the request for Purchase of compression (CPM) unit; Rental of cold therapy unit (CTU) for two (2) weeks; and Purchase of inferential (IF) unit is denied as there is a lack of documented evidence to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of compression (CPM) unit: 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)

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

Decision rationale: The CA MTUS is silent regarding the request. The ODG do not recommend compression units or continuous passive motion for the treatment of rotator cuff injuries. On review of the current literature there have been insufficient clinical trials that have shown a benefit with compression units for rotator cuff injuries. Many of the clinical documents were handwritten and illegible. The clinical documents did not provide a clear rationale for use of the compression units outside of current guideline recommendations. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.

Rental of cold therapy unit (CTU) for two (2) weeks: 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)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation (ODG), Shoulder, Continuous-flow cryotherapy & Forearm, Wrist, & Hand, Cold packs

Decision rationale: As per the guidelines, the cold therapy unit is only recommended during the first few days of acute complaint. Many of the clinical documents were handwritten and illegible. The clinical documents indicate that the patient sustained injury in 2006 and there is no clear rationale provided for the requested use of the cold therapy unit outside of current guideline recommendations. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.

Purchase of inferential (IF) unit: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The guidelines do not recommend interferential unit as an isolated intervention. According to the guidelines an interferential unit can be considered when pain has been ineffectively controlled with medications and conservative care, uncontrolled pain in the setting of substance abuse, significant postoperative pain and unable to participate in therapy, or unresponsive to conservative care. If the patient fits into one of these criteria a one-month trial

may be appropriate. The clinical documents did not establish the patient as meeting one of the above criteria. Additionally, it is unclear if the patient has undergone a one-month trial with an interferential unit. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.