

Case Number:	CM13-0027168		
Date Assigned:	11/22/2013	Date of Injury:	08/05/2011
Decision Date:	01/23/2014	UR Denial Date:	09/03/2013
Priority:	Standard	Application Received:	09/20/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and Pain Management and is licensed to practice in Ohio and Texas. 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 physician 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 72-year-old male who reported an injury on 08/05/2011. The patient is currently diagnosed with cervical spine sprain and strain, left shoulder impingement, left elbow lateral epicondylitis, and left wrist tendinitis. The patient was recently seen by [REDACTED] on 08/01/2013. The patient complained of persistent shoulder pain with popping and difficulty lifting. Physical examination revealed tenderness to palpation, diminished range of motion, positive impingement testing, tenderness to the cervical paraspinal muscles, and decreased range of motion of the cervical spine. Treatment recommendations included a left shoulder arthroplasty, preop evaluation, and a followup in 5 to 6 weeks following surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgistim 4 1-2 months rental, plus supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Interferential Current Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121.

Decision rationale: Surgistim4 unit delivers interferential, neuromuscular, high volt pulsed and pulse direct current stimulation. Interferential stimulation is supported by California MTUS

when a patient's pain is not controlled due to side effects or lack of medication effectiveness. If there is a history of substance abuse, or if the patient has been unresponsive to conservative measures or is unable to exercise due to postoperative pain. Both the high volt pulsed and pulse direct current stimulation modalities are considered galvanic stimulation, which is considered investigational. Neuromuscular stimulation is recommended for post stroke rehabilitation and postoperative knee orthopedic indications. Given that the criteria for the multiple stimulation modalities have not been met, the current request cannot be determined as medically appropriate. As such, the request for Surgistim4 1-2 months rental plus supplies is non-certified.

Surgistim4 (after 1-2 month rental), then purchase and supplies are needed: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Continuous Passive Motion (CPM): length of use 1-60 days: 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); Shoulder chapter regarding CPM.

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

Decision rationale:

Cold therapy system, purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Shoulder chapter, Continuous-flow cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Continuous Flow-Cryotherapy

Decision rationale: The Official Disability Guidelines state continuous flow cryotherapy is recommended as an option after surgery, but not for non-surgical treatment. Postoperative use generally may be up to 7 days, including home use. The current request for a purchase of a cold therapy system does not fall within Guideline recommendations. Therefore, the request for cold therapy system, purchase cannot be determined as medically appropriate, and is non-certified.

