

Case Number:	CM13-0032423		
Date Assigned:	12/11/2013	Date of Injury:	09/05/2011
Decision Date:	03/06/2014	UR Denial Date:	09/24/2013
Priority:	Standard	Application Received:	10/08/2013

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, has a subspecialty in Interventional Spine 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 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 57-year-old female with date of injury on 09/05/2011. The progress report dated 09/06/2013 by [REDACTED] indicates that the patient's diagnoses include: Right shoulder impingement syndrome with SLAP tear, distal clavicle, acromioclavicular joint degenerative joint disease, subacromial impingement, status post industrial right shoulder injury. The patient continues with right shoulder pain which persists after the patient had previously undergone surgery for the cervical spine. The patient had an MRI of the right shoulder on 08/12/2013 that revealed a superior labral tear, tendinosis of the distal rotator cuff, and subacromial bursitis with subacromial impingement syndrome. There was no full thickness rotator cuff or labral tear identified. The patient was considered an excellent candidate for right shoulder arthroscopic subacromial decompression, distal clavicle resection, and labral and/or cuff debridement as indicated versus repair. A request was made for postoperative electrical stim unit for 90 days, a sling with abduction pillow, a continuous passive motion unit for 45 days, and a cold therapy unit for 90 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

Rental of an electrical stim unit for 90 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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 116.

Decision rationale: The patient continues with right shoulder pain and has been recommended for arthroscopic surgery of the right shoulder. Regarding TENS unit therapy, the guidelines state that it is not recommended as a primary treating modality, but a 1-month home-based TENS unit trial may be considered as a non-invasive conservative option, if used as an adjunct to a program of evidenced-based functional restoration. The treating physician is requesting a 90-day rental. Without an adequate 30-day trial with functional benefit reported, this request is not in accordance with the guidelines. Therefore, the requested electrical stim unit rental is not medically necessary or appropriate at this time.

A sling with a large abduction pillow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 561-563. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder

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

Decision rationale: The patient continues with right shoulder pain and is being recommended for arthroscopic surgery of the right shoulder. MRI findings from 08/12/2013 reveal a superior labral tear, tendinosis of the distal rotator cuff, and subacromial bursitis with subacromial impingement syndrome. There was no full-thickness rotator cuff or labral tear identified. The MTUS guidelines are silent on postoperative abduction pillow slings. The Official Disability Guidelines recommend this as an option following an open repair of large and massive rotator cuff tears. As the documentation does not appear to indicate the patient has a full-thickness rotator cuff or labral tear, the sling with abduction pillow is not reasonable. Therefore, the requested sling is not medically necessary or appropriate at this time.

Rental of a CPM unit for 45 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

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

Decision rationale: The patient continues with right shoulder pain and is being referred for arthroscopic shoulder surgery for decompression and distal clavicle resection. The MTUS guidelines are silent on continuous passive motion units. The Official Disability Guidelines do not recommend continuous passive motion for shoulder rotator cuff problems, but recommend as an option for adhesive capsulitis. This patient does not have adhesive capsulitis. Therefore, the requested CPM unit rental is not medically necessary or appropriate.

Rental of a cold therapy unit for 90 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 555-556. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder

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

Decision rationale: The patient continues with right shoulder pain and is being recommended for arthroscopic surgery with decompression, distal clavicle resection, and labral and/or cuff debridement. The MTUS guidelines are silent on continuous-flow cryotherapy units for the postoperative shoulder. The Official Disability Guidelines state that continuous-flow cryotherapy units are recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. The request for a cold therapy unit rental for 90 days exceeds the recommended 7 days allowed by the Guidelines. Therefore, the requested cold therapy unit rental is not medically necessary or appropriate.