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| Case Number: | CM13-0047278 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 10/29/2010 |
| Decision Date: | 08/29/2014 | UR Denial Date: | 10/21/2013 |
| Priority: | Standard | Application Received: | 11/01/2013 |

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 Occupational Medicine, has a subspecialty in Preventive 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic shoulder pain reportedly associated with an industrial injury of October 29, 2010. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; transfer of care to and from various providers in various specialties; and consultation with a shoulder surgeon, who suggested pursuit of a shoulder arthroscopy procedure. In a utilization review report dated October 21, 2013, the claims administrator partially certified a request for a continuous cooling unit/CT unit as a seven-day rental of the same, denied a request for a pain pump, denied a request for a shoulder sling/immobilizer, and denied a request for SurgiStim two-month rental with associated supplies. The applicant's attorney subsequently appealed. The applicant did undergo an electrodiagnostic testing of the left upper extremity dated March 21, 2013, which was interpreted as normal. MR arthrography of March 19, 2013, was also notable for evidence of earlier labral repair with impingement syndrome, osteoarthritis, and tendinitis also evident. On June 6, 2013, the applicant apparently returned to the attending provider and was described as set to undergo a shoulder surgery on June 23, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electrodes x 4, AC adaptor x 1, S&H x 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation Topic-Galvanic Stimulation Topic Page(s): 121, 117.

Decision rationale: These requests all represent derivative or companion requests, requests associated with the SurgiStim device. Since the SurgiStim device was deemed not medically necessary, the derivative or companion requests for electrodes, and AC adaptor, and shipping and handling are likewise deemed not medically necessary.

CTU x1 (purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and shoulder chapters.

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

Decision rationale: The MTUS does not address the topic of continuous cooling device usage. As noted in the ODG Chronic Pain Chapter, Continuous-Flow Cryotherapy Topic, continuous cooling devices are recommended for postoperative use purposes, for up to seven days. The CTU/continuous cooling unit purchase request, thus, runs counter to ODG principles and parameters. No rationale for a purchase of the device was provided in the face of the unfavorable ODG position on the same. Therefore, the request is not medically necessary.

SurgiStim 2 months rental with supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation). Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation Topic - Galvanic Stimulation Topic Page(s): 121, 117.

Decision rationale: As noted in the product description, the SurgiStim device is a form of multimodality stimulator which includes galvanic stimulation or high-voltage stimulation, and neuromuscular electrical stimulation. Several of these modalities, however, carry unfavorable recommendations in the MTUS Chronic Pain Medical Treatment Guidelines. For instance, neuromuscular stimulation is, per page 121 of the MTUS Chronic Pain Medical Treatment Guidelines, recommended only in the poststroke rehabilitative context as opposed to the chronic pain context or perioperative pain context reportedly present here. Similarly, page 117 of the MTUS Chronic Pain Medical Treatment Guidelines states that galvanic stimulation is not recommended and considered investigation for all indications. No rationale for provision of the

device in question was proffered in the face of the unfavorable MTUS positions on the same. Therefore, the request is not medically necessary.

Left shoulder sling/immobilizer: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder: Sling/Immobilizer.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 9, Table 9-3, page 204, usage of a sling is considered an option in the treatment of acute pain associated with a rotator cuff tear. By implication, then, usage of a sling/immobilizer could be temporarily supported postoperatively, particularly as the Third Edition ACOEM Guideline Shoulder Chapter also recommends usage of slings and/or shoulder supports for postoperative pain as a transitory means of advancing the activity level. For all the stated reasons, then, the request is medically necessary.

Pain pump x 1 (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: Shoulder: Pain pump.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder Chapter, Postoperative Pain Pump Topic.

Decision rationale: The MTUS does not address the topic. As noted in the ODG Shoulder Chapter, Postoperative Pain Pump Topic, postoperative pain pumps are "not recommended." In this case, the attending provider has not furnished any compelling applicant-specific narrative rationale or medical evidence so as to offset the unfavorable ODG position on the same. Therefore, the request is not medically necessary.