

Case Number:	CM13-0050951		
Date Assigned:	12/27/2013	Date of Injury:	03/04/2011
Decision Date:	05/07/2014	UR Denial Date:	10/21/2013
Priority:	Standard	Application Received:	11/13/2013

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 Orthopedic Surgery 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:

This 64-year-old female reported an onset of sharp right shoulder pain on 3/4/11 feeding newsprint into a press. Right shoulder x-rays on 4/25/13 documented acromioclavicular joint arthrosis and generalized osteopenia; there was no significant glenohumeral joint narrowing. The 5/14/13 left shoulder MRI documented mild tendinosis of the distal subscapular tendon, otherwise normal prescription without evidence of tear or retraction. The 9/23/13 treating physician report cited persistent right shoulder pain, tenderness, stiffness and weakness. Right shoulder exam findings documented moderate to marked global loss of range of motion, severe supraspinatus tenderness, mild greater tuberosity and AC joint tenderness, positive subacromial crepitus, and positive compression and impingement test. The patient had failed conservative treatment. Authorization was reportedly pending for right shoulder arthroscopy with possible arthroscopic decompression with acromioplasty, resection of the coracoacromial ligament and/or bursa, Mumford procedure, manipulation under anesthesia, and capsular release. Post-operative requests included a cold therapy unit, E-Stim unit for 90 days, CPM unit, and sling with large abduction pillow. The 10/21/13 utilization review decision recommended partial certification of the cold therapy unit for 7-day rental, non-certification of the E-Stim unit, and partial certification of the CPM unit for 4-week rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

E-STIM FOR A PERIOD OF 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Page(s): 114-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Electrical stimulation.

Decision rationale: Under consideration is a request for an E-Stim unit (HCPCS E1399) for a period of 90 days. This request for an electrical stimulation unit has been presented using a miscellaneous durable medical equipment code. The Chronic Pain Medical Treatment Medical Guidelines provide specific criteria for transcutaneous electrotherapy in chronic pain based on the particular electrical modality being requested. Some electrotherapies, like TENS and interferential, have limited support following a 30-day trial, if there is evidence that other appropriate pain modalities (including medication) have been tried and failed. Other electrotherapies are not recommended for pain. Relative to the shoulder, the Official Disability Guidelines do not recommend electrical stimulation as there is a lack of evidence regarding efficacy. Given the absence of guideline support in general for electrical stimulation of the shoulder, this request for an E-Stim unit for a period of 90 days is not medically necessary.

CONTINUOUS PASSIVE MOTION 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 OFFICIAL DISABILITY GUIDELINES (ODG) SHOULDER, CONTINUOUS PASSIVE MOTION (CPM)

Decision rationale: Under consideration is a request for a continuous passive motion (CPM) unit for use following the right shoulder surgery. The California MTUS is silent regarding continuous passive motion (CPM). The Official Disability Guidelines do not recommend CPM for shoulder rotator cuff problems, but state these units are an option for adhesive capsulitis. The utilization review of 10/21/13 recommended partial certification of the CPM unit for 4 weeks rental. There is no compelling reason in the medical records to support the medical necessity of continued used of CPM beyond the 4-weeks already certified. Therefore, this request for a continuous passive motion (CPM) unit is not medically necessary.

COLD THERAPY 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 OFFICIAL DISABILITY GUIDELINES (ODG) SHOULDER, CONTINUOUS-FLOW CRYOTHERAPY

Decision rationale: Under consideration is a request for a cold therapy unit. The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines do not recommend cold compression therapy in the shoulder but state that continuous-flow cryotherapy is an option for up to 7 days. The 10/21/13 utilization review decision recommended partial certification of a cold therapy unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request for a cold therapy unit is not medically necessary.