

Case Number:	CM13-0052521		
Date Assigned:	12/27/2013	Date of Injury:	03/31/2006
Decision Date:	05/08/2014	UR Denial Date:	11/06/2013
Priority:	Standard	Application Received:	11/15/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in Texas and Ohio. 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 injured worker is a 43-year-old male who reported an injury on 03/31/2006. The mechanism of injury information was not provided in the medical record. The injured worker underwent an arthroscopic revision of the right shoulder with decompression and distal clavicle resection on 04/19/2013 by [REDACTED]. Orthopedic evaluation dated 08/21/2013 reports the injured worker continued to experience right wrist pain including the forearm with associated frequent numbness and tingling in the medial nerve distribution with his condition adversely affected by activities including lifting, gripping, grasping, squeezing, finger dexterity, and fine manipulation. Relative to his left shoulder, the injured worker reported experiencing continued pain with decreased mobility and function as well. There was noted tenderness to palpation at the distal forearm and wrist over the flexor greater than extensor tendons and to a lesser extent over the 1st dorsal extensor compartment with Finkelstein's test minimally painful. Tinel's sign over the transverse carpal ligament and Phalen's testing was positive for distal migrating paresthesias in the median nerve distribution. Clinical examination of the left shoulder revealed normal contour without deformity. There was no evidence of scapular winging. Palpation was notable for tenderness over the subacromial region, supraspinatus tendon, and acromioclavicular joint. Palpatory tenderness was also present over the parascapular region involving the upper trapezius, levator scapulae, and rhomboid musculature with associated hypertonicity. A tender myofascial trigger point was palpable with upper trapezial musculature. Range of motion of the left shoulder was restricted. The request was sent for right wrist carpal tunnel release with possible flexor tenosynovectomy and median neurolysis to be performed. The requested service is for continuous passive motion device, Surgi-stim unit, and Coolcare cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

SURGI-STIM 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), PAIN CHAPTER, NEUROMUSCULAR ELECTRICAL STIMULATION (NMES DEVICES)

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

Decision rationale: California MTUS Guidelines do not address Surgi-stim units in particular; however, the requested unit is a muscle stimulator. Therefore, this reviewer will refer to the neuromuscular stimulation guidelines. Per California MTUS Guidelines, neuromuscular electrical stimulation is not recommended. It is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. As there is no documentation in the medical records suggesting that the injured worker has a diagnosis of a stroke and no documentation of any type of major knee surgeries that could support medical necessity for use of the requested service to stimulate quadriceps muscles, the medical necessity for this request cannot be determined at this time and the request for Surgi-stim unit is non-certified.

■■■■■ **COLD THERAPY UNIT:** Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563. 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: California MTUS/ACOEM does not address the use of cryotherapy; however it does support occasional application of hot/cold packs. Per Official Disability Guidelines, it is stated that continuous-flow cryotherapy is recommended as an option after surgery, but not for non-surgical treatment. Postoperative treatment is generally not to exceed more than 7 days including home use. As the request is non-specific as to if the request is for the 7-day rental or purchase of a ■■■■■ cold therapy unit, medical necessity cannot be determined at this time. As there is need of clarification as to the exact request (rental or purchase), the request for ■■■■■ cold therapy unit is non-certified.

HOME CONTINUOUS PASSIVE MOTION DEVICE: 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, CONTINUOUS PASSIVE MOTION (CPM) DEVICE

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 (CPM) Device

Decision rationale: California MTUS/ACOEM does not address the use of continuous passive motion devices. The injured worker did undergo a rotator cuff repair; the Official Disability Guidelines do not recommend the use of continued passive motion for the injured worker's surgical procedure. There is no documentation in the medical records suggesting the injured worker has a diagnosis of adhesive capsulitis. Therefore, medical necessity for continued passive motion treatment cannot be determined at this time. As such, the request for continuous passive motion or CPM machine is non-certified.