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| Case Number: | CM13-0059716 | | |
| Date Assigned: | 12/30/2013 | Date of Injury: | 12/17/2009 |
| Decision Date: | 04/29/2014 | UR Denial Date: | 11/19/2013 |
| Priority: | Standard | Application Received: | 12/03/2013 |

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 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 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 patient is a 41 year old male with a date of injury of 12/17/2009. The listed diagnoses per [REDACTED] are: Lumbar radiculopathy, Left shoulder pain, and Status post left shoulder arthroscopic subacromial decompression, partial anterior acromioplasty with bursectomy (02/28/2013). According to a report dated 08/26/2013 by [REDACTED], the patient presents with low back pain that radiates to the left lower extremity. The patient also complains of neck pain and left shoulder pain. Patient reports an increase in left shoulder pain and increase in low back spasms. Physical examination revealed range of motion of the lumbar spine is decreased secondary to pain. There is spinal tenderness in the L4-S1 level. Examination of the shoulder revealed tenderness on palpation.

IMR ISSUES, DECISIONS AND RATIONALES

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

request for a 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), Treatment Index, 11th Edition (web), 2013 Shoulder, 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), Continuous-Flow Cryotherapy.

Decision rationale: This patient presents with low back, neck and left shoulder pain. Patient is status post left shoulder surgery (02/28/2013). The treating physician is requesting a Cold Therapy Unit. Review of progress reports before and following the 02/28/2013 shoulder surgery does not include any request for a cold therapy unit and there is no indication the patient used this device post operatively. Therefore, it is presumed the request for the cold therapy unit is for residual pain following the surgery. The MTUS and ACOEM guidelines do not discuss cold therapy units. Therefore, ODG Guidelines are referenced. ODG Guidelines has the following regarding continuous-flow cryotherapy: "Recommended as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated." The ODG Guidelines are clear on the duration of postoperative use of continuous-flow cryotherapy. The use of the cold therapy unit outside of the postoperative 7 days is not medically necessary, and recommendation is for denial.

18 pairs of Electrodes: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, (ICS) Page(s): 118-120.

Decision rationale: This patient presents with low back, neck and left shoulder pain. Patient is status post left shoulder surgery (02/28/2013). The treating physician is requesting 18 electrode supplies. The requested supplies would appear appropriate if the MTUS criteria for the use of the Interferential unit were met. The requested supplies for the unit are not medically necessary as the documentation does not support the use of the device. Recommendation is for denial.

Interferential Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Page(s): 118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Stimulation, (ICS) Page(s): 118-120.

Decision rationale: This patient presents with low back, neck and left shoulder pain. Patient is status post left shoulder surgery (02/28/2013). The request is for an Interferential unit. The MTUS Guidelines page 118 to 120 states that Interferential Current Stimulation is not recommended as an isolated intervention. The listed patient selection criteria include post-operative pain, which this patient suffers from. MTUS states that if criteria are met, then a one-

month trial would be appropriate. The use of an IF unit is appropriate for this patient given the patient's surgery. However, surgery was on 2/28/13 and it is not known whether the IF unit is requested for post-operative pain. At any rate, even if the criteria are met, MTUS recommends trying the unit for one-month before a home unit is provided. Given that the request for IF unit is without a specific request for one-month trial, recommendation is for denial.

Shoulder Exercise Kit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Page(s): 46.

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

Decision rationale: This patient presents with low back, neck and left shoulder pain. Patient is status post left shoulder surgery (02/28/2013). The treating physician is requesting a "shoulder exercise kit." The ACOEM, MTUS and ODG do not discuss shoulder exercise kits. However, exercise is recommended in MTUS, ACOEM, and ODG guidelines. ODG specifically recommends exercise for the shoulder for multiple disorders. ODG states, "Shoulder disorders may lead to joint stiffness more often than other joint disorders. Therapeutic exercise, including strengthening, should start as soon as it can be done without aggravating symptoms." Although exercise is recommended, it is unclear as to what the "shoulder excise kit" encompasses. Without knowing what the "kit" details, one cannot make a recommendation regarding its appropriateness based on the guidelines. There is no discussion regarding what exercises are to be performed and what kind of monitoring will be done. Recommendation is for denial.