

Case Number:	CM13-0069960		
Date Assigned:	01/03/2014	Date of Injury:	01/29/2012
Decision Date:	06/04/2014	UR Denial Date:	11/18/2013
Priority:	Standard	Application Received:	12/23/2013

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:

This case involves a 56 year-old female with a 1/25/12 industrial injury claim. She has been diagnosed with bilateral shoulder impingement syndrome, right worse than left. According to the 10/28/13 orthopedic report from [REDACTED], the patient presents with bilateral shoulder pain. She had an injection, that helped for a few days, but the pain returned. She had conservative care including PT, chiropractic, acupuncture, activity modification, and injections. [REDACTED] states she is a candidate for arthroscopic subacromial decompression and debridement. On 11/18/13 UR recommended against the purchase of a thermocool hot/cold contrast compression unit; the purchase of a Combo care4 electrical stimulator; and 30 days of CPM therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE PURCHASE OF THERMOCOOL HOT AND COLD CONTRAST THERAPY WITH COMPRESSION: Upheld

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

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, Online, Cold Compression Therapy.

Decision rationale: The patient presents with bilateral shoulder pain and is anticipating arthroscopic subacromial decompression for impingement syndrome. I have been asked to review for hot/cold compression therapy system purchase for the shoulder. MTUS/ACOEM did not discuss this, so ODG guidelines were consulted. ODG guidelines, specifically states cold compression therapy is not recommended in the shoulder. The request is not in accordance with ODG guidelines.

ONE PURCHASE OF COMBO CARE 4 ELECTROTHERAPY UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, TENS Page(s): 114-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-121.

Decision rationale: The patient presents with bilateral shoulder pain and is anticipating arthroscopic subacromial decompression for impingement syndrome. I have been asked to review for a Combo Care 4 electrical stimulator unit for purchase. The physician states this is multimodality stimulator that does TENS, NMES and interferential stimulation. MTUS specifically states NMES is not recommended. I am not able to offer partial certification, as the NMES is part of the multimodality stimulator. The whole ComboCare 4 unit cannot be recommended as being in accordance with MTUS guidelines because the NMES portion is not recommended.

30 DAYS OF CONTINUOUS PASSIVE MOTION (CPM) THERAPY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Online Version, Shoulder (Acute & Chronic) Chapter, Continuous passive motion (CPM).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Online Version, Shoulder (Acute & Chronic) Chapter, Continuous passive motion (CPM).

Decision rationale: The patient presents with bilateral shoulder pain and is anticipating arthroscopic subacromial decompression for impingement syndrome. The patient is only reported as having rotator cuff impingement syndrome. There is no evidence of adhesive capsulitis. The patient was able to abduct the right shoulder to 100 degrees and flex to 130 degrees. MTUS/ACOEM did not discuss CPM, so ODG guidelines were consulted. ODG states CPM units are: "Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week" The request for a CPM unit for impingement syndrome of the rotator cuff is not in accordance with ODG guidelines.