

Case Number:	CM14-0007531		
Date Assigned:	02/10/2014	Date of Injury:	08/04/2010
Decision Date:	06/24/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/21/2014

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 Oklahoma, Texas, California, and Tennessee. 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 45 year old female whose date of injury is 08/04/2010. The mechanism of injury is described as continuous trauma. The injured worker has a history of prior rotator cuff repair on 03/21/12 but continued with pain and limited range of motion. MR arthrogram of the right shoulder dated 09/23/13 revealed findings consistent with recurrent tear of the supraspinatus tendon. Follow up note dated 11/05/13 indicates that right shoulder range of motion is flexion 110, extension 40, abduction 95, adduction 40, internal rotation 35 and external rotation 85 degrees. The injured worker was authorized for repeat rotator cuff repair.

IMR ISSUES, DECISIONS AND RATIONALES

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

POST-OP DME: E-STIM UNIT FOR HOME USE FOR 90 DAYS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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, TENS (transcutaneous electrical nerve stimulation)

Decision rationale: Based on the clinical information provided, the request for post-op DME e-stim unit for home use for 90 days is not recommended as medically necessary. The Official

Disability Guidelines support the use of TENS post-stroke to improve passive humeral lateral rotation, but there is limited evidence to determine if the treatment improves pain. (Price, 2000) For other shoulder conditions, TENS units are not supported by high quality medical studies. Therefore, the injured worker does not meet ODG criteria for e-stim unit.

COLD THERAPY UNIT FOR HOME USE X 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: 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: Based on the clinical information provided, the request for cold therapy unit for home use x 90 days is not recommended as medically necessary. The injured worker has been authorized to undergo repeat rotator cuff repair. The Official Disability Guidelines would support cold therapy unit for up to 7 days postoperatively, and the current request is grossly excessive.

CONTINUOUS PASSIVE MOTION (CPM) UNIT FOR HOME USE X 45 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: 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)

Decision rationale: Based on the clinical information provided, the request for continuous passive motion unit for home use x 45 days is not recommended as medically necessary. The injured worker has been authorized to undergo repeat rotator cuff repair. The Official Disability Guidelines support continuous passive motion for adhesive capsulitis, but not for shoulder rotator cuff problems. Therefore, the injured worker does not meet ODG criteria for the unit.

SLING WITH LARGE ABDUCTION PILLOW: 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 Chapter, Postoperative abduction pillow sling

Decision rationale: Based on the clinical information provided, the request for sling with large abduction pillow is not recommended as medically necessary. The Official Disability Guidelines

support postoperative abduction pillow sling as an option following open repair of large and massive rotator cuff tears. This injured worker does not present with a large and massive rotator cuff tear and therefore does not meet ODG criteria.