

Case Number:	CM14-0103238		
Date Assigned:	09/16/2014	Date of Injury:	11/14/2010
Decision Date:	10/15/2014	UR Denial Date:	06/16/2014
Priority:	Standard	Application Received:	07/03/2014

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 Anesthesia has a subspecialty in Acupuncture & Pain Medicine 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 injured worker is a 56-year-old female with date of injury of 11/14/10 with related neck, back, left shoulder, left elbow, and left wrist pain. Per progress report dated 7/15/14, neck pain was rated 8.5/10, shoulder pain was rated 9/10, back pain was 9/10 and radiated into the left leg, also causing weakness, left elbow pain was rated 9/10, and swelling into the fingers was noted. She was approved for a left shoulder arthroscopic procedure. Treatment to date has included surgery, physical therapy, and medication management. The date of UR decision was 6/16/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

█ Cold Therapy Recovery System w/ Wrap qty 7.0 x35 day rental: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Continuous-flow cryotherapy

Decision rationale: The MTUS is silent on the use of cold therapy units. The ODG states continuous-flow cryotherapy is "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 usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting." As the ODG only supports the use of cold therapy units for up to 7 days, 35-day rental is not medically necessary.

████████ DVT Prevention System 35day rental: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Venous Thrombosis

Decision rationale: The MTUS is silent on DVT prevention systems. The ODG recommends treatment for patients who are at a high risk of developing venous thrombosis. However, the documentation submitted for review do not indicate that the injured worker would be on bed rest following surgery. Additionally, the documentation submitted does not indicate that the injured worker is at risk for deep vein thrombosis. Therefore, the request for ██████████ DVT Prevention System 35 day rental is not medically necessary and appropriate.

████████ STIM Purchase w/3mos supply: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.sevensesdm.com/force-stimulator/>

Decision rationale: Per internet search, the ██████████ STIM unit combines TENS with transcutaneous electrical joint stimulation (TEJS). The MTUS is silent on the use of TEJS. MTUS Chronic Pain Medical Treatment Guidelines do not recommend TENS as a primary treatment modality, but support consideration of a one-month home-based TENS trial used as an adjunct to a program of evidence-based functional restoration. Furthermore, criteria for the use of TENS includes pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, and a documented one-month trial period stating how often the unit was used, as well as outcomes in terms of pain relief and function. The documentation submitted for review do not contain evidence of successful trial with the ██████████ STIM, as such, the request for ██████████ STIM Purchase w/3 mos supply is not medically necessary and appropriate.

Shoulder CPM unit rental w pad qty 30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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: The MTUS is silent on the use of shoulder CPM rentals. Per ODG TWC with regard to shoulder CPM: "Not recommended after shoulder surgery or for nonsurgical treatment. (Raab, 1996) (BlueCross BlueShield, 2005) An AHRQ Comparative Effectiveness Review concluded that evidence on the comparative effectiveness and the harms of various operative and nonoperative treatments for rotator cuff tears is limited and inconclusive. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain, and one study found no difference in range of motion or strength." As the request is not recommended by the guidelines, it is not medically necessary.

Conductive Garment qty 2.0: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 120.

Decision rationale: With specific regard to conductive garments, the MTUS states: A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person." The documentation submitted for review contains no evidence of successful trial or the injured worker's inability to apply stimulation pads alone or with the help of another person. Furthermore, as the requested stimulation unit was deemed not medically necessary, the request for conductive garment is also not medically necessary.