

Case Number:	CM14-0107934		
Date Assigned:	08/01/2014	Date of Injury:	12/05/2013
Decision Date:	09/22/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/11/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 49-year-old male who reported an injury on 12/05/2013, secondary to a fall. The injured worker was evaluated on 05/08/2014. Previous conservative treatment is noted to include physical therapy, medication management, and bracing. Current diagnoses are previous rotator cuff repair with recurrent impingement syndrome and distal clavicle arthrosis. The injured worker presented with ongoing right shoulder pain and activity limitation. Physical examination revealed tenderness at the subacromial bursa, tenderness to palpation of the AC (acromioclavicular) joint, positive Neer's and Hawkin's testing, positive AC joint stress testing, positive Jobe impingement sign, limited range of motion, 4/5 strength, and intact sensation. It is noted that the injured worker underwent an MR arthrogram of the right shoulder in 01/2014. Treatment recommendations at that time included an arthroscopic acromioplasty and distal clavicle resection. A Request for Authorization was then submitted on 06/19/2014 for a cold therapy unit with a pad, CPM plus soft goods, and interferential unit with supplies. An operative report was submitted on 06/19/2014, indicating that the injured worker underwent a diagnostic arthroscopy with distal clavicle resection and acromioplasty.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective usage of a CPM machine / kit for 21 day rental DOS (6/19/14): 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)- TWC.

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.

Decision rationale: The Official Disability Guidelines do not recommend continuous passive motion for shoulder rotator cuff problems, but recommend continuous passive motion as an option for adhesive capsulitis, up to 4 weeks/5 days per week. The injured worker does not maintain a diagnosis of adhesive capsulitis. Therefore, the current request cannot be determined as medically appropriate.

Retrospective usage of a cold therapy unit and supplies/ pad x 7 -14 day rental (06/19/2014): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Procedure Summary.

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: The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative generally may be up to 7 days, including home use. Therefore, the current request for a 7 to 14 day rental of a cold therapy unit with supplies exceeds guideline recommendations. As such, the request is not medically appropriate.

Retrospective usage of an IF (interferential) unit and supplies x 30 day rental (DOS 6/19/14): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), TWC, Shoulder Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation (ICS) Page(s): 117-121.

Decision rationale: California MTUS Guidelines do not recommend interferential current stimulation as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments. There should be documentation that pain is ineffectively controlled due to diminished effectiveness of medication or side effects, a history of substance abuse, or significant pain from postoperative conditions. There is no documentation of an unresponsiveness to conservative measures. Therefore, the current request does not meet California MTUS Guideline criteria. As such, the request is not medically appropriate.

Prospective usage of a CPM machine/kit x 21 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 (ODG)- TWC.

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.

Decision rationale: The Official Disability Guidelines do not recommend continuous passive motion for shoulder rotator cuff problems, but recommend continuous passive motion as an option for adhesive capsulitis, up to 4 weeks/5 days per week. The injured worker does not maintain a diagnosis of adhesive capsulitis. Therefore, the current request cannot be determined as medically appropriate.

Prospective usage of a cold therapy unit and supplies/ pad x 7- 14 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- TWC, Shoulder Procedure Summary.

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: The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative generally may be up to 7 days, including home use. Therefore, the current request for a 7 to 14 day rental of a cold therapy unit with supplies exceeds guideline recommendations. As such, the request is not medically appropriate.

Prospective usage of an IF(interferential) unit and supplies x 30 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- TWC Shoulder Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation (ICS) Page(s): 117-121.

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