

Case Number:	CM14-0015449		
Date Assigned:	02/28/2014	Date of Injury:	03/17/2011
Decision Date:	12/19/2014	UR Denial Date:	01/24/2014
Priority:	Standard	Application Received:	02/06/2014

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 & 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 54-year-old female with a date of injury of 03/17/2011. The earliest progress report provided for review is from 10/17/2013. According to this report, the patient presents with left shoulder, left hand and left elbow pain. Examination revealed decreased range of motion in the left hand and positive Dugas test on the left. Deep tendon reflexes are 2+/4. According to progress report 08/23/2013, the patient presents with continued left shoulder pain. Examination of the left shoulder revealed exquisite tenderness over the anterior and lateral aspect of the acromion. Flexion, abduction, and rotation caused accentuated pain. The listed diagnoses are: 1. Shoulder impingement syndrome, left. 2. Partial tear, rotator cuff, left. 3. Subacromial bursitis, left. 4. AC joint cartilage disorder, left. Under treatment plan, the treating physician notes, "It is felt that the patient should undergo arthroscopy with arthroscopic surgery of the left shoulder." The treater requests durable medical equipments for postoperative use including interferential current unit with supplies, MicroCool machine, and home exercise kit. Utilization review denied the requests on 01/24/2014. The medical file provided for review includes treatment reports from 06/06/2013 through 10/17/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

MICRO COOL: 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 (Acute & Chronic) Chapter, continuous-flow cryotherapy

Decision rationale: This patient presents with chronic left shoulder pain. The current request is for Micro cool. On 08/23/2013, the treater recommended the patient undergo left shoulder surgery and requested durable medical equipment for postoperative care including a MicroCool unit "to help reduce swelling and allow early exercise." The utilization review's discussion regarding the denial for the MicroCool was not provided in the medical file. 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." There is no indication that the requested surgery has been approved or performed. ODG does not recommend continuous-flow cryotherapy for nonsurgical treatment; therefore, the request is not medically necessary.

HOME EXERCISE KIT: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Home exercise kits under the Shoulder (Acute & Chronic) section

Decision rationale: This patient presents with chronic left shoulder pain. The current request is for Home exercise kit. ODG guidelines state the following regarding Home exercise kits under the Shoulder (Acute & Chronic) section, "Recommended. See Exercises, where home exercise programs are recommended; & Physical therapy, where active self-directed home physical therapy is recommended. In this RCT a specific shoulder home exercise program resulted in 69% good outcomes versus 24% in the sham exercise group, and 20% of patients in the specific exercise group subsequently chose to undergo surgery versus 63% in the control group. (Holmgren, 2012)" Home exercise kits are recommended by ODG; therefore, the request is medically necessary.

IFC UNIT: 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 interferential current stimulation Page(s): 118-120.

Decision rationale: This patient presents with chronic left shoulder pain. The current request is for IF unit. The MTUS Guidelines page 118 to 120 states interferential current stimulation is not recommended as an isolated intervention. "There is no quality evidence of effectiveness except in conjunction with recommended treatments including return to work, exercise, and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included the studies for back pain, jaw pain, soft tissue shoulder pain, cervical pain, and post-operative knee pain." For indications, MTUS mentions intolerability to meds, post-operative pain, history substance abuse, etc. For these indications, one-month trial is then recommended. In this case, it is unknown if the requested shoulder surgery was authorized or performed. At any rate, MTUS recommends trying the unit for one-month before a home unit is provided. Given that the request is for an IF unit without a specific request for one-month trial, therefore, the request is not medically necessary.