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| Case Number: | CM14-0017337 | | |
| Date Assigned: | 06/11/2014 | Date of Injury: | 08/04/2010 |
| Decision Date: | 07/21/2014 | UR Denial Date: | 02/05/2014 |
| Priority: | Standard | Application Received: | 02/11/2014 |

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 55-YEAR-OLD MALE WHO REPORTED AN INJURY ON 08/04/2010. THE MECHANISM OF INJURY WAS THE INJURED WORKER WAS CHANGING A TIRE, TRIPPED OVER A PIPE FROM A DRAIN SYSTEM THAT WAS LYING ON THE GROUND, AND FELL TO THE GROUND LANDING ON HIS RIGHT ARM AND SHOULDER. PRIOR TREATMENTS INCLUDED A RIGHT ROTATOR CUFF REPAIR, DECOMPRESSION, AND DISTAL CLAVICLE RESECTION ON 10/20/2010. THE DOCUMENTATION OF 12/20/2013 ADDITIONALLY REVEALED A REQUEST FOR A CONTINUOUS PASSIVE MOTION DEVICE FOR AN INITIAL PERIOD OF 45 DAYS TO ASSIST IN RESTORING RANGE OF MOTION, A COLD CARE THERAPY UNIT, AND A SURGI-STIM UNIT FOR AN INITIAL PERIOD OF 90 DAYS. IT WAS ADDITIONALLY INDICATED THAT IF THE SURGI-STIM UNIT PROVIDED CONTINUING FUNCTIONAL AND SYMPTOMATIC BENEFIT AFTER 90 DAYS, THE PURCHASE OF THE UNIT WOULD BE RECOMMENDED. THE SURGICAL TREATMENT THAT WAS RECOMMENDED WAS AN ARTHROSCOPIC RE-EVALUATION, ARTHROSCOPIC RIGHT SHOULDER ROTATOR CUFF REVISION REPAIR, DECOMPRESSION, DISTAL CLAVICLE RESECTION, CORACOPLASTY, AND POSSIBLE BICEPS TENOTOMY VERSUS TENODESIS. THE SURGICAL INTERVENTION AND POSTOPERATIVE SHOULDER PHYSICAL THERAPY WERE APPROVED.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME CPM (CONTINUOUS PASSIVE MOTION) DEVICE FOR PURCHASE: 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), Shoulder Procedure Summary and Blue Cross of California Medical Policy.

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 INDICATE THAT CPM MACHINES THAT CONTINUOUS PASSIVE MOTION IS NOT RECOMMENDED FOR SHOULDER ROTATOR CUFF PROBLEMS. THEY ARE RECOMMENDED FOR ADHESIVE CAPSULITIS. THERE WAS A LACK OF DOCUMENTATION OF EXCEPTIONAL FACTORS TO WARRANT NONADHERENCE TO GUIDELINE RECOMMENDATIONS. THERE WAS A LACK OF DOCUMENTATION INDICATING A NECESSITY FOR A PURCHASE VERSUS RENTAL. GIVEN THE ABOVE, THE REQUEST FOR HOME CPM (CONTINUOUS PASSIVE MOTION) DEVICE FOR PURCHASE IS NOT MEDICALLY NECESSARY.

COOLCARE COLD THERAPY UNIT FOR 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), 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, CONTINOUS FLOW CRYOTHERAPY.

Decision rationale: THE OFFICIAL DISABILITY GUIDELINES INDICATE THAT A CONTINUOUS FLOW CRYOTHERAPY MACHINE IS APPROPRIATE FOR 7 DAYS POSTOPERATIVELY. THE REQUEST AS SUBMITTED FAILED TO INDICATE THE DURATION OF RENTAL FOR THE COLD CARE THERAPY UNIT. GIVEN THE ABOVE, THE REQUEST FOR COOLCARE COLD THERAPY UNIT FOR RENTAL IS NOT MEDICALLY NECESSARY.

SURGI-STIM UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION Page(s): 118.

Decision rationale: THE CALIFORNIA MTUS GUIDELINES DO NOT RECOMMEND INTERFERENTIAL CURRENT STIMULATION AS AN ISOLATED INTERVENTION. THE CLINICAL DOCUMENTATION SUBMITTED FOR REVIEW INDICATED THE INJURED WORKER HAD MET THE CRITERIA FOR SURGICAL INTERVENTION AND POSTOPERATIVE PHYSICAL THERAPY. HOWEVER, THE REQUEST AS SUBMITTED FAILED TO INDICATE THE DURATION OF USE FOR THE REQUESTED PRODUCT AND FAILED TO INDICATE IF THE REQUEST WAS FOR RENTAL OR PURCHASE. GIVEN THE ABOVE, THE REQUEST FOR SURGI-STIM UNIT IS NOT MEDICALLY NECESSARY.