

Case Number:	CM14-0018744		
Date Assigned:	04/18/2014	Date of Injury:	05/01/2007
Decision Date:	07/02/2014	UR Denial Date:	02/06/2014
Priority:	Standard	Application Received:	02/13/2014

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 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 claimant is a 49-year-old female who was injured on May 9, 2011. Recent clinical records available for review indicate an operative report of March 28, 2014 indicating the claimant underwent a diagnostic arthroscopy to the right shoulder, subacromial decompression, labral debridement and rotator cuff repair for full thickness rotator cuff tear. Preoperative assessment of January 8, 2014 indicated the claimant was with subjective complaints of both right shoulder pain, difficulty sleeping with examination findings showing positive Neer and Hawkins testing and positive impingement testing. Further physical examination or subjective complaints were not noted. The claimant at that date was noted to be status post bilateral carpal tunnel release in 2008. There were recommendations for orthopedic referral for further assessment of the claimant's carpal tunnel syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

EVALUATION AND TREATMENT BY ORTHOPEDIC SURGEON FOR CARPAL TUNNEL SYNDROME.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2007), Chapter 7, page 127.

Decision rationale: Based on California ACOEM Guidelines, orthopedic referral for assessment of carpal tunnel syndrome would not be indicated. This individual, while with previous history of carpal tunnel release in 2008, gives no current clinical subjective complaints or objective findings indicative of a carpal tunnel diagnosis. The specific request for referral to an orthopedic surgeon in absence of subjective complaints or examination findings and particularly in absence of treatment would not be indicated. The request is not medically necessary.

THERMOCOOL COMPRESSION SYSTEM: 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 Chapter, Cold Compression Therapy Section.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

Decision rationale: The California ACOEM Guidelines would not support the role of purchase of a thermal cool compressive system. While Guidelines would recommend topical use of cold therapy during the first few days following acute injury, the purchase of the above device would not be indicated by Guideline criteria. The specific request in this case would not be supported and is not medically necessary.

COMBO CARE 4 ELECTROTHERAPY DEVICE: 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 Chapter, Interferential Current Stimulation Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118 and 120-121.

Decision rationale: The California MTUS Guidelines currently would not support the role of a combination care device in the postoperative setting. A ComboCare IV device is a combination of interferential and neuromuscular electrical stimulation would not be indicated. Neuromuscular electrical stimulation has no current role in the acute or chronic pain setting or postoperative care setting and is currently only indicated for post injury use following a stroke. The specific request for this device following the claimant's surgery would not be indicated and thus not medically necessary.

CONTINUOUS PASSIVE MOTION MACHINE: 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 Chapter.

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 Section.

Decision rationale: The California MTUS Guidelines are silent. When looking at Official Disability Guideline criteria, CPM devices for the shoulder are not recommended. Currently there is no long term literature to demonstrate or indicate efficacy with the use of this device versus control groups. The specific request for CPM following shoulder procedure would not be indicated thus, the request is not medically necessary.

SHOULDER SLING WITH 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), Shoulder Chapter.

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, Pillow Sling Section.

Decision rationale: The California MTUS Guidelines are silent. When looking at Official Disability Guideline criteria, an abduction pillow sling would be indicated. This individual did undergo a large rotator cuff repair performed arthroscopically. The postoperative use of a sling with abduction pillow given the claimant's surgical findings would be appropriate.