

Case Number:	CM14-0121820		
Date Assigned:	08/06/2014	Date of Injury:	06/19/2012
Decision Date:	10/01/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/01/2014

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 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:

This is a 55-year-old female with a 6/19/12 date of injury. The mechanism of injury occurred when she was lifting groceries and a water case and developed neck pain. According to a handwritten 6/18/14 progress report, the patient had right shoulder pain. Medications have provided pain relief. It is noted that another physician recommended a right shoulder arthroscopic rotator cuff repair, decompression, and distal clavicle resection. The majority of this note was illegible. Objective findings: limited ROM of right shoulder, crepitus, tenderness, strength of 4/5, and positive impingement test. Diagnostic impression: right rotator cuff tear. Treatment to date: medication management, activity modification, physical therapy. A UR decision dated 7/23/14 denied the request for surg-stim unit rental, coolcare cold therapy unit, and home CPM device rental. There is no compelling indication to provide postsurgical treatment for 3 consecutive months without interval evaluation of its therapeutic benefits. The patient is diagnosed with rotator cuff impingement and was recommended with rotator cuff repair for which guidelines do not recommend a CPM unit. Guidelines endorse continuous-flow cryotherapy for up to seven days postoperative use. Further clarification is needed regarding the Coolcare cold unit provision.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urgent Surgi- Stim Unit Rental x90days: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-118.

Decision rationale: The SurgiStim unit incorporates interferential, NMS/EMS, and galvanic therapies into one unit. However, there is no documentation of a rationale identifying why a combined electrotherapy unit would be required as opposed to a TENS unit. In addition, MTUS does not consistently recommend interferential, NMS, and galvanic electrotherapy. Therefore, the request for Urgent Surgi- Stim Unit Rental x90 days was not medically necessary

Urgent Coolcare Cold Therapy Unit: Upheld

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

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

Decision rationale: CA MTUS does not address this issue. ODG states that 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. It is noted that the provider has recommended a right shoulder arthroscopic rotator cuff repair. However, there is no documentation indicating that this surgery has been authorized and performed. As a result, this request for postoperative treatment cannot be substantiated. Therefore, the request for Urgent Coolcare Cold Therapy Unit was not medically necessary

Urgent Home CPM Device Rental x45 days: Upheld

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

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

Decision rationale: CA MTUS does not address this issue. ODG does not consistently support the use of CPM in the postoperative management of rotator cuff tears; but CPM treatment for adhesive capsulitis provides better response in pain reduction than conventional physical therapy. It is noted that the provider has recommended a right shoulder arthroscopic rotator cuff repair. However, there is no documentation indicating that this surgery has been authorized and performed. As a result, this request for postoperative treatment cannot be substantiated. Therefore, the request for Urgent Home CPM Device Rental x45 days was not medically necessary.