

Case Number:	CM14-0128393		
Date Assigned:	08/15/2014	Date of Injury:	07/30/2010
Decision Date:	09/24/2014	UR Denial Date:	08/01/2014
Priority:	Standard	Application Received:	08/12/2014

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:

This is a 53 year old female with a 7/30/2010 date of injury. The exact mechanism of the original injury was not clearly described. A progress reported dated 6/23/14 noted subjective complaints of persistent left shoulder pain despite all attempts at aggressive conservative management. Objective findings included decreased ROM, tenderness to palpation of supraspinatus and AC joint. There was no shoulder instability. Motor strength 4/5 left upper extremity. Sensation was intact. The patient is planned on surgical intervention of the left shoulder. Diagnostic Impression: Left shoulders SLAP tear, subacromial impingement, partial thickness supraspinatus tendon tear. Treatment to Date: medication management, physical therapy. A UR decision dated 8/1/14 modified the request for 1 cold therapy unit for 7 days rental. Guidelines recommend generally up to 7 days. There are no factors noted to warrant use beyond guideline recommendations. It also denied the request for 90 days rental of Surgi-Stim unit. This device is noted to contain multiple modalities that include interferential current stimulation, galvanic stimulation, and neuromuscular electrical stimulation. CA MTUS does not recommend the use of galvanic stimulation and neuromuscular electrical stimulation. It also denied the request for 45 days rental of a continuous passive motion device. Guidelines indicate that use of this modality is not recommended after shoulder surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 cold therapy unit (associated with approved left shoulder arthroscopy): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines 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) knee chapter.

Decision rationale: CA MTUS does not specifically 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. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. However, there is no duration of treatment outline for the proposed treatment modality. Therefore, the request for 1 cold therapy unit (associated with approved left shoulder arthroscopy) was not medically necessary.

90 days' rental of Surgi-Stim unit (associated with approved left shoulder arthroscopy):
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

Decision rationale: The OrthoStim 4 unit incorporates interferential, TENS, 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, CA MTUS does not consistently recommend interferential, NMS, and galvanic electrotherapy. Therefore, the request for 90 days rental of Surgi-Stim unit (associated with approve left shoulder arthroscopy) was not medically necessary.

45 days' rental of a continuous passive motion device (associated with approved left shoulder arthroscopy): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines 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.

Decision rationale: CA MTUS does not specifically 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. However, the requested treatment modality is clearly for post-surgical therapy in which one of the diagnoses was a rotator cuff tear. There is no evidence that

CPM improves function, pain, or range of motion following shoulder surgery. Therefore, the request for 45 days rental of a continuous passive motion device (associated with approved left shoulder arthroscopy) was not medically necessary.