

Case Number:	CM14-0169011		
Date Assigned:	10/17/2014	Date of Injury:	07/15/2013
Decision Date:	12/03/2014	UR Denial Date:	09/25/2014
Priority:	Standard	Application Received:	10/14/2014

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, has a subspecialty in Sports Medicine and is licensed to practice in Alaska and Texas. 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 52-year-old female who reported injury on 07/15/2013. The injured worker was noted to be certified for an arthroscopic right rotator cuff repair, decompression, and distal clavicle resection on 09/26/2014. The mechanism of injury was repetitive clerical activities. The prior treatments included work restrictions, physical therapy, and NSAIDs. On 06/23/2014 there was a comprehensive orthopedic second opinion surgical consultation. The injured worker was found to have decreased right shoulder range of motion, super supraspinatus tenderness, moderate greater tuberosity tenderness bilaterally, severe AC joint tenderness on the right and moderate AC joint tenderness on the left, and positive bilateral subacromial crepitus. The injured worker's testing was noted to be affected by pain bilaterally. The injured worker's strength was 4/5 bilaterally in forward flexion, abduction, and internal and external rotation. The injured worker had a positive AC joint compression test, impingement 1, 2, and 3 tests bilaterally. The results were severe on the right and moderate on the left. The injured worker underwent an ultrasound study of the bilateral shoulders on 02/26/2014 revealing bilateral chronic full thickness large rotator cuff tears. The diagnoses included ultrasound confirmed right shoulder rotator cuff tear, status postindustrial bilateral shoulder sprain and strain injuries on 07/15/2013. The treatment plan included an arthroscopic evaluation, right rotator cuff repair, decompression and distal clavicle resection bilaterally. There was a Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home continuous passive motion device initial period of 45 days: Upheld

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

Decision rationale: The Official Disability Guidelines do not recommend continuous passive motion for shoulder rotator cuff problems. The clinical documentation submitted for review indicated the injured worker had a full thickness shoulder rotator cuff tear. As such, this request would not be supported. Given the above, the request for home continuous passive motion device initial period of 45 days is not medically necessary.

Surgistim unit initial period of 90 days: 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 TENS, NMES, Interferential Current Stimulation, Galvanic Stimulation Page(s): 114-116, 117,.

Decision rationale: The California MTUS recommends a one month trial of a TENS unit as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial there must be documentation of at least three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. They do not recommend Neuromuscular electrical stimulation (NMES devices) as there is no evidence to support its' use in chronic pain. They do not recommend Interferential Current Stimulation (ICS) as an isolated intervention. Galvanic Stimulation is not recommended. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant nonadherence to guideline recommendations. The surgical intervention was found to be medically necessary. Given the above, the request for Surgistim unit initial period of 90 days is not medically necessary.

Cool care cold therapy unit: Upheld

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

Decision rationale: The Official Disability Guidelines recommend continuous flow cryotherapy for 7 days postoperatively. The clinical documentation submitted for review indicated the

injured worker would be undergoing surgical intervention. However, the request as submitted failed to indicate whether the unit was for rental or purchase and failed to indicate the duration of care. Given the above, the request for cool care cold therapy unit is not medically necessary.