

Case Number:	CM14-0024169		
Date Assigned:	06/11/2014	Date of Injury:	01/27/2012
Decision Date:	07/15/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	02/26/2014

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, has a subspecialty in Pain Management, 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 patient is a 69-year-old with a date of injury of January 27, 2012. The listed diagnoses according to [REDACTED] are status post left knee scope (2004), right knee arthroscopic surgery (2004), right shoulder partial thickness rotator cuff tear, status post left shoulder rotator cuff repair (2008), and right knee meniscus tear with meniscal cyst. According to the February 14, 2014 progress report by [REDACTED], the patient is status post right knee and right shoulder surgery. Ultrasound of the shoulders from January 10, 2013 revealed large partial thickness rotator cuff tear involving the right distal supraspinatus tendon and all four left rotator cuff tendons intact without evidence of recurrent tear on the left. MRI of the right knee from March 1, 2013 revealed a large tear of the body and anterior horn of the lateral meniscus with a moderate sized meniscal cyst. The left knee MRI showed degenerative changes but no definite recurrent medial meniscal tear. [REDACTED] supplement report January 7, 2013 states he concurs with [REDACTED] and [REDACTED] that the patient is a candidate for right knee surgery and right shoulder surgery for correction of pathology. On February 2, 2014 the patient underwent right shoulder and right knee surgery. The request is for Cold Therapy unit, Surgistim and Shoulder Continuous passive motion (CPM). Utilization review modified the certification for the Cold therapy and denied the request for Surgi-stim and shoulder CPM.

IMR ISSUES, DECISIONS AND RATIONALES

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

COLD THERAPY: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the Non-MTUS Official Disability Guidelines (ODG) Shoulder Chapter.

Decision rationale: This patient presents with a right shoulder rotator cuff tear and right knee anterior horn of the lateral meniscus with a meniscal cyst. The patient underwent right knee and right shoulder surgery on February 2, 2014. The treater is requesting a Cold Therapy Unit. Utilization review from February 18, 2014 modified the certification to seven day rental for post-operative use. The MTUS and ACOEM guidelines do not discuss cold therapy units. Therefore, ODG Guidelines are referenced. ODG Guidelines has the following regarding continuous-flow cryotherapy: "Recommended as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to seven days including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated." The ODG recommends the duration of postoperative use of continuous-flow cryotherapy to be 7 days. The request for cold therapy is not medically necessary or appropriate.

SURGISTIM: 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 Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: This patient presents with a right shoulder rotator cuff tear and right knee anterior horn of the lateral meniscus with a meniscal cyst. The patient underwent right knee and right shoulder surgery on February 2, 2014. The treater is requesting a Surgi Stim. Surgi Stim is a brand name neuromuscular electrical stimulation device. The Chronic Pain Medical Treatment Guidelines states, "Not recommended. NMES (neuromuscular electrical stimulation) is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain." This device is intended for patient following a stroke and is not supported for chronic pain or post operative use. The request for Surgistim is not medically necessary or appropriate.

SHOULDER CONTINUOUS PASSIVE MOTION (CPM): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the Non-MTUS Official Disability Guidelines (ODG), Shoulder Chapter.

Decision rationale: This patient presents with a right shoulder rotator cuff tear and right knee anterior horn of the lateral meniscus with a meniscal cyst. The patient underwent right knee and right shoulder surgery on February 2, 2014. The treater is requesting a Shoulder Continuous passive motion (CPM). The ACOEM and MTUS do not discuss Continuous passive motion

devices. Therefore, ODG guidelines were consulted. ODG under its shoulder chapter has the following regarding continuous passive motion devices, "Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to five days weekly for four weeks." ODG further states, "Rotator cuff tears: Not recommended after shoulder surgery or for nonsurgical treatment." CPM for rotator cuff tears are not support by ODG. The request for a shoulder CPM is not medically necessary or appropriate.