

Case Number:	CM14-0040060		
Date Assigned:	06/27/2014	Date of Injury:	12/12/2013
Decision Date:	07/28/2014	UR Denial Date:	03/19/2014
Priority:	Standard	Application Received:	04/04/2014

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 53-year-old gentleman, who was injured in a work-related accident on December 12, 2013. The records available for review include a March 19, 2014, utilization review certifying the request for a left shoulder arthroscopy Bankart repair, rotator cuff repair, subacromial decompression and Mumford procedure. This request is for the following in the post-operative period: the 30-day rental of a cryotherapy device; the 30-day rental of an interferential unit; the 60-day rental of a continuous passive motion machine; and the four-day use of a pain pump. Available clinical records are not pertinent to the specific postoperative requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit for thirty (30) days: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205. Decision based on Non-MTUS Citation Non-MTUS Hegmann K, Occupational Medicine Practice Guidelines, 2nd Ed (2008 Revision), page 555-556; and Official Disability Guidelines (ODG); Treatment in Worker's Compensation, 18th Edition, 2013 Updates: shoulder procedure - Continuous-flow cryotherapy.

Decision rationale: The MTUS/ACOEM Guidelines support the use of cold applications in the home setting. The Official Disability Guidelines only recommend the use of continuous flow cryotherapy units for seven-day use. Therefore, the request for a thirty (30) day use exceeds the recommended guidelines and cannot be supported as medically necessary.

IF (Interferential) unit for thirty (30) 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 Interferential Current Stimulation (ICS) Page(s): 118.

Decision rationale: The Chronic Pain Guidelines indicate that interferential units are not recommended for isolated intervention in the post-surgical setting, as no quality evidence supports their effectiveness except when used as part of a chronic pain management program that includes return to work, exercise and medications. The request does not meet guideline recommendations. Therefore, this request is not established as medically necessary.

CPM (Continuous passive motion) machine for sixty (60) days: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment in Worker's Compensation, 18th Edition, 2013 Updates: shoulder procedure - Continuous passive motion (CPM).

Decision rationale: The Official Disability Guidelines do not support the use of a continuous passive motion (CPM) device following a rotator cuff repair, because recent randomized clinical controls and trials failed to demonstrate benefit with use of CPM following acute rotator cuff repair procedures. Therefore, the use of this device, particularly for the 60-day period as requested, would not be established as medically indicated.

Pain pump for four (4) days: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - Postoperative pain pump.

Decision rationale: The Official Disability Guidelines indicate that the use of a pain pump following shoulder surgery would not be medically necessary as there is currently no evidence to support the efficacy of pain pumps in the immediate post-operative setting following shoulder procedures. Therefore, this request would not be indicated.