

Case Number:	CM14-0053682		
Date Assigned:	07/07/2014	Date of Injury:	12/12/2012
Decision Date:	08/07/2014	UR Denial Date:	03/20/2014
Priority:	Standard	Application Received:	04/22/2014

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 injured worker is a 63-year-old male who reported an injury on 12/12/2012. The mechanism of injury was noted within the documentation provided as a slip and fall. As per the clinical note dated 04/01/2014, the injured worker complained of moderate left shoulder pain exacerbated with heavy lifting, reaching and pushing activities. Upon physical examination of the left shoulder, the documentation noted that forward flexion was 150/180, abduction was 150/180, external rotation (in abduction) was 70/90, external rotation (outside) was 70/60 and internal rotation (behind the back) was to T10/T8. The examination also revealed positive results for Neer's, Hawkins and Jobe's tests (pain with resisted abduction). Tenderness was noted to the left shoulder at the acromioclavicular (AC) joint. In addition, anterior and posterior acromioclavicular (AC) joint stress test results were positive. Motor strength testing of the left shoulder was noted with forward flexion of 5/5, scapular abduction 4/5, external rotation 4/5, internal rotation 5/5 and lift off test at 5/5. As per the clinical note dated 05/13/2014, the injured worker was 6 weeks postoperative arthroscopic rotator cuff repair of the left shoulder and noted improving with diminished pain. Within the documentation provided, the injured worker's diagnoses included left shoulder impingement and a rotator cuff tear. Within the documentation provided, it was noted that the injured worker's previous treatments was included cortisone injection, home exercise program and medications. Medications were not noted on the clinical notes dated 04/01/2014 and 05/13/2014. The provider's request was for 18 postoperative physical therapy, 1 continuous passive motion (CPM) machine rental for 4 weeks, 1 VascuTherm rental for 4 weeks, 1 electrical muscle stimulator rental for 4 weeks and 1 hot and cold therapy unit with compression for 4 weeks. The Request for Authorization form and rationale were not included within the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

18 post operative physical therapy sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10, 26 - 27.

Decision rationale: The injured worker has a history of left shoulder pain and is noted to have undergone arthroscopic rotator cuff repair. The California MTUS states that the general course of therapy means the number of visits and/or time interval which shall be indicated for postsurgical treatment for the specific surgery in the postsurgical physical medicine treatment recommendations. The initial course of therapy means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations. The general course of therapy for postsurgical rotator cuff syndrome/impingement syndrome recommendations is 24 visits over 14 weeks. There is a lack of documentation provided to indicate that the injured worker has had the initial course of postsurgical physical medicine treatment. As with the guideline recommendations, the initial course of therapy for postsurgical rotator cuff repair is 12 visits over 7 weeks. The requested treatment plan of 18 postoperative physical therapy sessions exceeds the initial therapy guidelines. Based on the above noted, the request is not medically necessary and appropriate.

1 continuous passive motion machine rental for 4 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Official Disability Guidelines, Continuous Passive Motion; Shoulder (Acute and Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous Passive Motion (CPM).

Decision rationale: The injured worker has a history of left shoulder pain and is noted to have undergone an arthroscopic rotator cuff repair. The Official Disability Guidelines state that continuous passive motion (CPM) for rotator cuff tears is not recommended after shoulder surgery or for nonsurgical treatment. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain, and one study found no difference in range of motion or strength. As with the ODG recommendation that CPM devices are not recommended for treatment for postsurgical rotator cuff repairs, the request for 1 continuous passive motion machine rental for 4 weeks is not medically necessary and appropriate.

1 Vascutherm rental for 4 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Official Disability Guidelines, Shoulder (Acute and Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Cold Compression Therapy.

Decision rationale: The injured worker has a history of left shoulder pain and is noted to have undergone an arthroscopic rotator cuff repair. The Official Disability Guidelines (ODG) state that cold compression therapy is not recommended in the shoulder, as there are no published studies. It may be an option for other body parts. There has been a randomized control trial (RCT) underway since 2008 to evaluate and compare clinical post-operative outcomes for patients using an active cooling and compression device and those using ice bags and elastic wrap after acromioplasty or arthroscopic rotator cuff repair, but the results are not available. VascuTherm is a device that is able to provide heat or cold compression therapy. As with the ODG recommendations, cold compression therapy is not recommended, as there are no clinical trials supporting its use over using an ice pack and elastic wrap after arthroscopic rotator cuff repair. Based on the above noted, the request is not medically necessary and appropriate.

1 electrical muscle stimulator rental for 4 weeks: Upheld

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

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

Decision rationale: The injured worker has a history of left shoulder pain and is noted to have undergone an arthroscopic rotator cuff repair. The California MTUS state transcutaneous electrical nerve stimulation (TENS) for postoperative pain is recommended as a treatment option for acute post-operative pain in the first 30 days post-surgery. The guidelines further state that the proposed necessity of the unit should be documented upon request. The clinical note dated 05/13/2014 noted the injured worker was 6 weeks postoperative and noted improving with diminished pain. The guideline recommendation of recommend use within the first 30 days post-surgery has since elapsed and there is a lack of documentation to indicate the medical necessity of use of the unit beyond the guideline recommendations. Additionally, as per the guidelines, the proposed necessity of the unit should be documented upon request; however, the rationale for the requested treatment was not noted within the documentation submitted for review. Based on the above noted, the request for 1 electrical muscle stimulator rental for 4 weeks is not medically necessary and appropriate.

1 hot and cold therapy unit with compression for 4 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Official Disability Guidelines, Shoulder (Acute and Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Cold Compression Therapy.

Decision rationale: The injured worker has a history of left shoulder pain and is noted to have undergone an arthroscopic rotator cuff repair. The Official Disability Guidelines (ODG) state that cold compression therapy is not recommended in the shoulder, as there are no published studies. It may be an option for other body parts. There has been a randomized control trial (RCT) underway since 2008 to evaluate and compare clinical post-operative outcomes for patients using an active cooling and compression device and those using ice bags and elastic wrap after acromioplasty or arthroscopic rotator cuff repair, but the results are not available. As with ODG recommendations, cold compression therapy is not recommended as there are no clinical trials supporting its use over using an ice pack and elastic wrap after arthroscopic rotator cuff repair, the request for 1 hot and cold therapy unit with compression is non-certified. Based on the above noted, the request is not medically necessary and appropriate.