

Case Number:	CM14-0065664		
Date Assigned:	07/11/2014	Date of Injury:	11/13/2012
Decision Date:	09/17/2014	UR Denial Date:	04/17/2014
Priority:	Standard	Application Received:	05/08/2014

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 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 female who reported an injury on 11/13/2012. The mechanism of injury was noted as cumulative trauma. Her diagnoses included right basilar joint arthrosis, complete tear right rotator cuff, status post right carpal tunnel release and left carpal tunnel syndrome. Other therapies included physical therapy and home exercise program. Diagnostic studies included unofficial MRI on 12/03/2013, which noted a full thickness tear in multiple locations throughout the rotator cuff. Surgical history included right carpal tunnel release on 08/26/2013. It was noted on the progress report dated 02/27/2014, the injured worker complained of pain and weakness in the right shoulder and pain in the right thumb exacerbated with gripping/grasping. She reported pain was, at times, severe. The objective findings of the right shoulder noted passive forward flexion was 160 degrees and there was pain and weakness elicited when testing the supraspinatus tendon against resistance. The right thumb examination revealed tenderness over the basilar joint and the injured worker was positive on the grind test. Medications included Ultram 50 mg every 6 hours as needed and Diclofenac 75 mg twice a day. The provider requested 6 weeks rental of a Surgi-Stim unit and 4 weeks rental of a shoulder continuous passive motion unit. The rationale for the requested treatment plan was not provided within the medical records. The Request for Authorization form was not provided within medical record submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 Weeks Rental of A Surgi-Stim Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Treatment for Workers' Compensation, Online Edition, Chapter: Shoulder. BlueCross BlueShield, 2005, Aetna, 2005.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: The injured worker has a history of right shoulder pain and weakness and right thumb pain. She has a history of preoperative physical therapy and underwent right carpal tunnel release and participated in postoperative physical therapy. The California MTUS Guidelines do not recommend an interferential current stimulation (ICS) as an isolated intervention. The Guidelines state that there is no quality evidence of effectiveness except in conjunction with recommended treatments including return to work, exercise and medications and limited evidence of improvement on those recommended treatments alone. The guidelines further state that ICS would possibly be appropriate if pain was ineffectively controlled due to diminished effectiveness of medications or side effects, there is a history of substance abuse, significant pain from postoperative conditions limit the ability to perform exercise program/physical therapy treatment or the patient is unresponsive to conservative measures (e.g. repositioning, heat/ice, etc.). The guidelines state if those criteria are met, then a 1 month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. The documentation provided noted the injured worker complained of right shoulder pain and diagnostic studies indicate a complete rotator cuff tear and the provider has requested surgery. However, the clinical documentation submitted for review failed to indicate that surgery was scheduled or had been performed. Additionally, the documentation provided failed to indicate if the injured worker's pain was ineffectively controlled with medications or if she had experienced significant adverse side effects that would diminish the effect of the medications. There is a lack of documentation to indicate any history of substance abuse that would warrant use of the requested treatment. There is lack of documentation to indicate that she would be at risk for significant pain from postoperative conditions, which would limit her ability to perform postoperative physical therapy. Additionally, there is a lack of documentation to indicate that she would be unresponsive to conservative measure postoperatively to warrant the device. Additionally, the provider's request exceeds the recommendation of a 1 month trial. The requested treatment failed to identify the time and frequency to be used and site to be applied. Based on the above criteria, the decision for 6 weeks rental of Surgi-Stim unit is not medically necessary.

4 Weeks Rental of a Shoulder Continuous Passive Motion Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Treatment for Workers' Compensation, Online Edition, Chapter: Shoulder. BlueCross BlueShield, 2005, Aetna, 2005.

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 right shoulder pain and weakness and right thumb pain. She has a history of preoperative physical therapy and underwent right carpal tunnel release and participated in postoperative physical therapy. The California MTUS/ACOEM Guidelines do not address the requested treatment plan. The Official Disability Guidelines (ODG) does not recommend continuous passive motion (CPM) unit after surgery or for nonsurgical treatment of rotator cuff tear. The documentation provided noted the injured worker complained of right shoulder pain and diagnostic studies indicate a complete rotator cuff tear and the provider has requested surgery. However, the clinical documentation submitted for review failed to indicate that surgery was scheduled or had been performed. The documentation provided failed to identify any significant objective functional deficits to warrant alternative treatments. Based on the provider's recommendation for rotator cuff surgery, use of a CPM unit is not supported by the guidelines. As such, the request for 4 weeks rental of a shoulder continuous passive motion unit is not medically necessary.