MAXIMUS Federal Services

Case Number:	CM14-0074625		
Date Assigned:	07/16/2014	Date of Injury:	09/28/2010
Decision Date:	09/24/2014	UR Denial Date:	05/02/2014
Priority:	Standard	Application Received:	05/22/2014

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 Surgeon, 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 50-year-old, female who injured her right shoulder on 09/28/10. The clinical records provided for review document that the claimant failed conservative treatment and was scheduled to undergo manipulation under anesthesia 04/11/14. This review is for a postoperative request for a 30 day rental of a CPM device, a three month use of a Pro Stim Stimulator unit and purchase of a portable heating pad.

IMR ISSUES, DECISIONS AND RATIONALES

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

Portable Heat Pad Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - ThermotherapyUnder study. For several physical therapy interventions and indications (eg, thermotherapy using heat, therapeutic exercise, massage, electrical stimulation, mechanical traction), there was a lack of evidence regarding efficacy. (Philadelphia, 2001).

Decision rationale: The California ACOEM Guidelines recommend the self-application of heat in the home setting for comfort. The Official Disability Guidelines recommend the use of a thermo therapy device is under study with no indication of its long term efficacy of benefit. Its specific use in this individual's post clinical setting of a manipulation to the shoulder would not be supported. Therefore, this request is not medically necessary.

Pro-Stim 5.0 plus 3 months supplies x 30 day trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Chronic Pain (updated 07/18/2009).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118, 120-121.

Decision rationale: California MTUS Chronic Pain Medical Treatment Guidelines would also not support purchase of a Pro-Stim V unit and supplies. According to the Chronic Pain Guidelines, Pro-Stim V unit is a combination therapy device containing both interferential and neuromuscular electrical stimulation. Presently neuromuscular electrical stimulation is not recommended in the acute or chronic pain setting. The use of this device for post procedural use following manipulation under anesthesia would not be supported. Therefore, this request is not medically necessary.

Shoulder Continuous Passive Motion (CPM) Machine with pads x 30 day rental: Upheld

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

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; Chapter shoulder: CPMNot recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Adhesive capsulitis: According to this RCT, CPM treatment for adhesive capsulitis provides better response in pain reduction than conventional physical therapy. The CPM group received CPM treatments for 1 h once a day for 20 days during a period of 4 weeks. The PT group had a daily physical therapy treatment including active stretching and pendulum exercises for 1 h once a day for 20 days during a period of 4 weeks. All patients in both groups were also instructed in a standardized home exercise program consisting of passive range of motion and pendulum exercises to be performed every day. In both groups, statistically significant improvements were detected in all outcome measures compared with baseline. Pain reduction, however, evaluated with respect to pain at rest, at movement and at night was better in CPM group. In addition the CPM group showed better shoulder pain index scores than the PT group. (Dundar, 2009) Because adhesive capsulitis involves fibrotic changes to the capsuloligamentous structures, continuous passive motion or dynamic splinting are thought to help elongate collagen fibers. (Page, 2010).

Decision rationale: California ACOEM Guidelines are silent. When looking at Official Disability Guidelines, the request for a CPM device for a 30 day rental would not be indicated. The ODG Guidelines in regards to CPM use for a diagnosis of adhesive capsulitis or post procedure for manipulation under anesthesia support the use of the device for four weeks, five days per week for a total of 20 sessions. The specific request in this case for a 30 day rental would exceed the ODG Guidelines and thus would not be indicated as medically necessary.