

Case Number:	CM14-0094243		
Date Assigned:	09/12/2014	Date of Injury:	02/01/2012
Decision Date:	11/25/2014	UR Denial Date:	06/11/2014
Priority:	Standard	Application Received:	06/20/2014

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:

This 47-year-old male construction worker sustained an industrial injury on 2/1/12. Injury occurred while he was hanging drywall and his tool belt got caught, causing him to fall and injure his right shoulder. He underwent right shoulder arthroscopic rotator cuff repair on 3/9/12. The 4/24/14 right shoulder MRI arthrogram impression documented prior rotator cuff surgery with no evidence of full thickness rotator cuff tear. There was thinning and irregularity of the undersurface of the supraspinatus tendon which may reflect a partial tear. Records indicated the patient was being followed by pain management for medication management. Subjective and functional benefit was documented with his medication regime of Tramadol, Naprosyn, Omeprazole, and Gabapentin. The 5/20/14 treating physician report cited persistent right shoulder pain aggravated by lifting, reaching, and pushing activities. Conservative treatment included extensive physical therapy, self-directed exercises, work modifications, anti-inflammatory medications, and corticosteroid injection without sustained improvement. Right shoulder exam documented range of motion limited to 150 degrees flexion/abduction and 70 degrees external rotation. Neer's, Hawkin's, and Jobe's tests were positive. Anterior and posterior acromioclavicular joint stress tests were positive. There was abduction and external rotation weakness. The diagnosis was previous rotator cuff repair with residual symptomatic impingement attenuated, partial rotator cuff tear, and acromioclavicular joint arthrosis. The treatment plan requested authorization for right shoulder arthroscopic distal clavicle resection, debridement, and possible rotator cuff repair. Additional requests were submitted for pre-op evaluation, post-op physical therapy, continuous passive motion (CPM) unit, cold compression unit, interferential unit, and arm sling. The 6/11/14 utilization review approved the requests for right shoulder arthroscopic subacromial decompression and debridement, pre-operative medical clearance, 12 physical therapy visits, and a post-op sling. The requests for 30-day rental of

durable medical equipment including continuous passive motion (CPM) device, interferential (IF) unit, and cold compression unit was denied based on the absence of guideline support for these units in patients undergoing right shoulder arthroscopy.

IMR ISSUES, DECISIONS AND RATIONALES

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

CPM x 30 days: 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); Continuous Passive Motion (CPM); Knee Chapter

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 California MTUS are silent regarding continuous passive motion (CPM) units. The Official Disability Guidelines do not recommend CPM units for rotator cuff problems. These units are recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Guideline criteria have not been met. There is no clinical evidence suggestive of adhesive capsulitis. There is no compelling reason to support the medical necessity of this unit in the absence of guideline support. Therefore, this request is not medically necessary.

IF Unit x30 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): 118-120.

Decision rationale: The California MTUS guidelines do not recommend interferential current (IFC) stimulation as an isolated intervention. Guidelines indicate that an IFC trial may be indicated for post-operative conditions if there is significant pain that limits the ability to perform exercise programs/physical therapy treatment. Guideline criteria have not been met. There is no indication that the patient will be unable to perform post-op physical therapy exercise or treatment, or that post-operative pain management will be ineffective. Therefore, this request is not medically necessary.

Cold Compression Unit x30 days: 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) Continuous Flow Cryotherapy

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 California MTUS is silent regarding cold compression devices. The Official Disability Guidelines state that cold compression therapy is not recommended in the shoulder. Guidelines state that there has been a randomized controlled trial 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. Given the absence of guideline support or a compelling reason to override the guidelines, this request is not medically necessary.