MAXIMUS Federal Services

Case Number:	CM14-0187230		
Date Assigned:	11/17/2014	Date of Injury:	02/01/2003
Decision Date:	01/05/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/10/2014

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 Fellowship trained in Pediatric Orthopedics, and is licensed to practice in Texas and Colarado. 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 70-year-old female who reported an injury on 02/01/2003, while working as a peace officer and private investigator. The injured worker sustained injuries to the bilateral shoulders as a result from continuous trauma and work related activities. The injured worker complained of shoulder pain. The MRI dated 03/25/2014 revealed near full thickness supraspinatus tear, subscapularis tendinosis, and subscapularis and biceps tendinosis and SLAP tears. Past treatments included physical therapy, cold and heat therapy, and anti-inflammatory medications. The patient reported her pain an 8/10 to 10/10 using the VAS. The physical examination dated 09/26/2014 revealed range of motion with flexion at the right at 35 degrees and the left at 160 degrees, extension 40 degrees to the right, and 40 degrees to the left. Supraspinatus tenderness was severe bilaterally. Muscle strength and tone revealed forward flexion of 4/5 to the right and 5/5 to the left; abduction 4/5 to the right and 5/5 to the left. The treatment plan included surgery to the shoulder, a CPM machine, a SurgiStim unit, and Coolcare cold therapy unit. The Request for Authorization was not submitted with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Home continuous passive motion CPM device, for an initial period of 45 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), Shoulder Chapter, 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) Continuous passive motion (CPM)

Decision rationale: The request for associated surgical services: home continuous passive motion CPM machine, for the initial period of 45 days, is not medically necessary. The Official Disability Guidelines do not recommend CPM machines for shoulder rotator cuff problems, but recommend as an option for adhesive capsulitis, up to 4 weeks/5 days a week. An AHRQ Comparative Effectiveness review concluded that evidence on the comparative effectiveness and the harms of various operative and nonoperative treatments for rotator cuff tear is limited and inconclusive. 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 such, the request for the CPM machine is not medically necessary.

Associated surgical service: Surgi Stim uni, for an initial period of 90 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Interferential Current Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 20.

Decision rationale: The request for associated surgical services: SurgiStim uni, for the initial period of 90 days, is not medically necessary. The California MTUS indicate that NMES devices are not recommended. NMES is used primarily as part of a rehabilitation program following stroke, and there is no evidence to support its use for chronic pain. There are no interventions or trials suggesting benefits from NMES for chronic pain. Additionally used for significant pain from postoperative conditions limiting the ability to perform exercise programs/physical therapy treatment or in response to conservative treatment postoperatively. The documentation was not evident that the injured worker would not be able to participate in physical therapy postoperatively, and there is no way to predict the injured worker would not be able to participate. As such, the request for Surgi Stim unit is not medically necessary.

Associated surgical service: Coolcare cold therapy unit: 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 Chapter, 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, Continuous-flow cryotherapy

Decision rationale: The request for associated surgical services: Coolcare cold therapy unit is not medically necessary. The Official Disability Guidelines recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. The prior request was modified to certify for 7 days, which the Official Disability Guidelines' indicate. However, they do not indicate after 7 days. Therefore, the request for Coolcare cold therapy unit is not medically necessary.