

Case Number:	CM14-0195034		
Date Assigned:	12/02/2014	Date of Injury:	09/19/2012
Decision Date:	01/28/2015	UR Denial Date:	10/22/2014
Priority:	Standard	Application Received:	11/21/2014

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 Minnesota. 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 60-year-old male with a date of injury of 9/19/2012. He complained of a right wrist injury when his arm was pinned between a coworker and a prep table. The treatment included medications, acupuncture, bracing, and physical therapy in March 2013. There was a cyst removed from the right wrist on 3/5/2013. An MRI scan of the cervical spine was performed on 9/7/2013. He underwent a transforaminal epidural steroid injection without significant benefit. He was noted to have limited range of motion of the right shoulder with weakness and positive provocative testing. An ultrasound evaluation of both shoulders was performed on 3/12/2014. The right shoulder ultrasound revealed prominent degenerative tearing at the supraspinatus greater tuberosity footprint but no retraction. There was right subacromial-subdeltoid bursitis and tenosynovitis of the biceps tendon. The ultrasound of the left shoulder revealed partial thickness tear of the supraspinatus tendon with background tendinosis, acromioclavicular arthritis, and subdeltoid-subacromial bursitis. Authorization was requested for arthroscopy of the right shoulder with subacromial decompression, distal claviclectomy, preoperative medical clearance, postoperative rehabilitation therapy, a home continuous passive motion device rental for 45 days, Surgi Stim unit rental for 90 days, and cold care cold therapy unit for purchase. The disputed issues pertain to the request for continuous passive motion device rental for 45 days, Surgi Stim unit rental for 90 days, and cold care cold therapy unit for purchase. Utilization review noncertified the request for the CPM machine and the Surgi Stim device. Cryotherapy unit was modified to a 7 day rental instead of purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

CPM Machine rental for 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)

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

Decision rationale: California MTUS guidelines do not address this issue. The ODG guidelines were therefore used. The guidelines do not recommend the use of continuous passive motion for rotator cuff surgery. However it is indicated as an option for adhesive capsulitis. Based upon guidelines, the request for the continuous passive motion device is not supported and as such, the medical necessity is not established.

Surgi Stim Unit rental for 90 days for the right shoulder: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118, 121.

Decision rationale: Surgi-stim is an electronic nerve and muscle stimulator and interferential stimulator. California MTUS guidelines do not recommend interferential current stimulation after surgery. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise, and modifications and limited evidence of improvement on those recommended treatments available. The findings from randomized trials were either negative or non-interpretible for recommendation due to poor study design and or methodological issues. Neuromuscular electrical stimulation devices are not recommended. Based upon the guidelines, the request for Surgi-stim is not supported and as such, the medical necessity is not established.

Coolcare cold therapy unit purchase: 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)

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

Decision rationale: California MTUS guidelines do not address this issue. ODG guidelines are therefore used. Continuous flow cryotherapy is recommended as an option after surgery for up to 7 days. It reduces pain, inflammation, swelling and need for narcotics. The rental for 7 days

was appropriate and medically necessary. However, the request as stated for purchase is not supported by guidelines and as such; the medical necessity is not established.