

Case Number:	CM14-0203081		
Date Assigned:	12/15/2014	Date of Injury:	08/08/2014
Decision Date:	02/05/2015	UR Denial Date:	11/19/2014
Priority:	Standard	Application Received:	12/04/2014

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 Rehab, has a subspecialty in Interventional spine 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 patient is a 68 year old male with an injury date of 08/08/14. Based on the 08/22/14 progress report provided by treating physician, the patient complains of increased right shoulder pain with weakness. Physical examination to the right shoulder on 11/07/14 revealed minimal indication of atrophy and non-tenderness. Positive Impingement and Hawkin's tests. Patient has had physical therapy, medications, as well as local injection to the right shoulder with initially mild improvement with recurrence of pain. Due to findings on MRI and due to his continuous symptoms, this patient will be a candidate for right shoulder arthroscopic rotator cuff repair. Patient is working full duty with no limitations per treater report dated 11/07/14. MRI of the Right Shoulder, per treater report dated 11/07/14- supraspinatus tendon tear with retraction approximately 22mm- subacromial and subdeltoid bursa fluid- reduce clearance between under surface subacromion and superior aspect of humeral head rising the possibility for an impingement situation- moderately hypertrophic AC joint
Diagnosis 08/22/14, 11/07/14- right shoulder rotator cuff with retraction
Diagnosis 10/06/14- right shoulder strain- right rotator cuff tendinitis
The utilization review determination being challenged is dated 11/19/14. Per UR letter dated 11/12/14, patient has been authorized Right Shoulder arthroscopic rotator cuff repair 11/19/14 - 02/19/15. The request for Cold Therapy Unit was modified to 7 day rental. Per UR letter dated 11/19/14, the request for CPM Machine was denied as "guidelines do not support the request.." Treatment reports were provided from 06/03/14 - 11/07/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, under Continuous-flow Cryotherapy.

Decision rationale: The patient presents with increased right shoulder pain with weakness. The request is for cold therapy unit. MRI of the Right Shoulder, per treater report dated 11/07/14 revealed supraspinatus tendon tear with retraction approximately 22mm. Physical examination to the right shoulder on 11/07/14 revealed minimal indication of atrophy and non-tenderness. Positive Impingement and Hawkin's tests. Patient is working full duty with no limitations per treater report dated 11/07/14. The MTUS and ACOEM Guidelines do not discuss water therapy units. ODG Guidelines Pain Chapter, under Continuous-flow Cryotherapy states, "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 use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated". Treater states that "patient has had physical therapy, medications, as well as local injection to the right shoulder with initially mild improvement with recurrence of pain. Due to findings on MRI and due to his continuous symptoms, this patient will be a candidate for right shoulder arthroscopic rotator cuff repair." Per UR letter dated 11/12/14, patient has been authorized Right Shoulder arthroscopic rotator cuff repair 11/19/14 - 02/19/15. The request appears to be for post-operative use following the proposed arthroscopic procedure. There is no documentation provided to indicate the exact type or model of cold therapy unit, nor whether it is for purchase or rental. The ODG Guidelines recommends the duration of postoperative use of continuous-flow cryotherapy to be 7 days. The patient is well-beyond the postoperative recovery duration of 7 days for which unit would be indicated. Therefore the request is not medically necessary.

CPM Machine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) Chapter, under Continuous passive motion (CPM).

Decision rationale: The patient presents with increased right shoulder pain with weakness. The request is for CPM Machine. MRI of the Right Shoulder, per treater report dated 11/07/14 revealed supraspinatus tendon tear with retraction approximately 22mm. Physical examination to the right shoulder on 11/07/14 revealed minimal indication of atrophy and non-tenderness. Positive Impingement and Hawkin's tests. Treater states that "patient has had physical therapy, medications, as well as local injection to the right shoulder with initially mild improvement with

recurrence of pain. Due to findings on MRI and due to his continuous symptoms, this patient will be a candidate for right shoulder arthroscopic rotator cuff repair." Patient is working full duty with no limitations per treater report dated 11/07/14. The ACOEM and MTUS do not discuss Continuous passive motion devices. ODG-TWC, Shoulder (Acute & Chronic) Chapter, under Continuous passive motion (CPM) states: "Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. See the Knee Chapter for more information on continuous passive motion devices. Rotator cuff tears: Not recommended after shoulder surgery or for nonsurgical treatment. (Raab, 1996)" Treater states that "patient has had physical therapy, medications, as well as local injection to the right shoulder with initially mild improvement with recurrence of pain. Due to findings on MRI and due to his continuous symptoms, this patient will be a candidate for right shoulder arthroscopic rotator cuff repair." Per UR letter dated 11/12/14, patient has been authorized Right Shoulder arthroscopic rotator cuff repair 11/19/14 - 02/19/15. The request appears to be for post-operative use following the proposed arthroscopic procedure. However, ODG does not support CPM for patient's condition. Therefore the request is not medically necessary.