

Case Number:	CM14-0021712		
Date Assigned:	05/07/2014	Date of Injury:	04/28/2011
Decision Date:	03/18/2015	UR Denial Date:	02/03/2014
Priority:	Standard	Application Received:	02/20/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Internal Medicine

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 is a 59 year old female with a work injury dated 04/28/2011. The mechanism of injury is not documented. According to submitted records the injured worker (IW) underwent right shoulder arthroscopic examination with finding of complete tear of the rotator cuff and synovitis on 03/27/2012. The IW underwent repair of the rotator cuff using Bio-Composite corkscrews. No further medical records are available for review. The provider had requested authorization for post op IF unit, post op pain pump and vital wraps system times 6 weeks. On 02/03/2014 utilization review non-certified the requests noting the following: Post op IF unit purchase - "There is no quality of evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications and limited evidence of improvement on those recommended treatments alone." Guidelines cited were MTUS. Post-op pain pump" - A pain pump is not required post shoulder surgery. Short term use of narcotic and or NSAID'S medications should suffice for pan control." Cited Guidelines were ODG. Vital wraps system times 6 weeks - "There is no medical rationale for costly CTU/compression unit after a routine knee scope. Home application of ice/cold packs will suffice for edema control. Compression units are not appropriate for DVT prophylaxis. This is more appropriately done with anti-coagulants." Cited guidelines were ACOEM. On 02/20/2014 the injured worker submitted an application for IMR review of the requested treatments: Post op IF unit purchase, post op pain pump and vital wraps system times 6 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op IF Unit Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203, Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page 114-121. Interferential Current Stimulation (ICS) Pages 1. Decision based on Non-MTUS Citation Work Loss Data Institute. Shoulder (acute & chronic). Encinitas (CA): Work Loss Data Institute; 2013 Jun 12. <http://www.guideline.gov/content.aspx?id=47591> ACOEM 3rd Edition. Bibliographic Source: Shoulder disorders. In: Hegmann KT, editor(s). Occupational medicine practice guidelines. Evaluation and management of common health problems and functional recovery in workers. 3rd ed. Elk Grove Village (IL): American College of Occupational and Environmental Medicine (ACOEM); 2011. p. 1-297. Table 2. Summary of Recommendations for Managing Shoulder Disorders. <http://www.guideline.gov/content.aspx?id=36626>

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines addresses interferential current stimulation (ICS). Interferential current stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretible for recommendation due to poor study design and methodologic issues. Although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support Interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 9 Shoulder Complaints states that physical modalities, such as massage, diathermy, cutaneous laser treatment, ultrasound treatment, transcutaneous electrical neurostimulation (TENS) units, and biofeedback are not supported by high-quality medical studies. ACOEM 3rd edition (2011) does not recommend interferential therapy for shoulder disorders. Work Loss Data Institute guidelines for the shoulder (acute & chronic) state that interferential current stimulation (ICS) is not recommended. Medical records document that on 03-27-12 the patient underwent right shoulder arthroscopic examination with the finding of complete tear of the rotator cuff, and the patient underwent repair of the rotator cuff. Interferential (IF) unit was requested. MTUS, ACOEM, and Work Loss Data Institute guidelines do not support the medical necessity of interferential current stimulation (ICS). Therefore, the request for post-operative IF unit purchase is not medically necessary.

Post-op Pain Pump: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder Chapter: Post Operative Pain Pump

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder (Acute & Chronic) Postoperative pain pump

Decision rationale: Medical Treatment Utilization Schedule (MTUS) does not address postoperative pain pumps. Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) indicate that a postoperative pain pump is not recommended. Three recent randomized controlled trials did not support the use of pain pumps. Medical records document that on 03-27-12 the patient underwent right shoulder arthroscopic examination with the finding of complete tear of the rotator cuff, and the patient underwent repair of the rotator cuff. Official Disability Guidelines (ODG) indicate that a postoperative pain pump is not recommended. The request for a postoperative pain pump is not supported by ODG guidelines. Therefore, the request for a postoperative pain pump is not medically necessary.

Vital wraps system x 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Shoulder (Acute & Chronic) Compression garments, Thermotherapy, Cold compression therapy

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses physical modalities. American College of Occupational and Environmental Medicine (ACOEM) Chapter 9 Shoulder Complaints indicates that physical modalities are not supported by high-quality medical studies. Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) states that compression garments are not generally recommended in the shoulder. Cold compression therapy is not recommended in the shoulder, as there are no published studies. Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) states that thermotherapy are under 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. Medical records document that on 03-27-12 the patient underwent right shoulder arthroscopic examination with the finding of complete tear of the rotator cuff, and the patient underwent repair of the rotator cuff. The request for a Vital Wrap System is not supported by MTUS, ACOEM, or ODG guidelines. Therefore, the request for Vital Wrap System for six weeks is not medically necessary.

Post-op Ultra Sling: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Post Op Pillow Sling

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213. Decision based on Non-MTUS Citation Shoulder (Acute & Chronic) Immobilization, Postoperative abduction pillow sling

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses immobilization. American College of Occupational and Environmental Medicine (ACOEM) Chapter 9 Shoulder Complaints states prolonged use of a sling only for symptom control is not recommended. If indicated, the joint can be kept at rest in a sling. Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) state that immobilization is not recommended as a primary treatment. Immobilization and rest appear to be overused as treatment. Postoperative abduction pillow sling is recommended as an option following open repair of large and massive rotator cuff tears. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. Medical records document that on 03-27-12 the patient underwent right shoulder arthroscopic examination with the finding of complete tear of the rotator cuff, and the patient underwent repair of the rotator cuff. Official Disability Guidelines (ODG) indicate that postoperative abduction pillow slings are not used for arthroscopic repairs. Medical records indicate arthroscopic repair. Therefore, the request for a post-operative Ultra Sling is not supported by ODG guidelines. Therefore, the request for post-operative Ultra Sling is not medically necessary.