

Case Number:	CM14-0024812		
Date Assigned:	06/13/2014	Date of Injury:	05/31/2012
Decision Date:	04/03/2015	UR Denial Date:	02/10/2014
Priority:	Standard	Application Received:	02/27/2014

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: Physical Medicine & Rehabilitation

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 59-year-old female who reported an injury on 05/31/2012. The injury reportedly occurred when the injured worker pulled out a heavy door and experienced an immediate onset of pain in the left shoulder and left knee. Her diagnoses included cervical spine sprain/strain, status post right shoulder arthroscopy, left shoulder strain, and chondromalacia of the left knee. Her past treatments were noted to include cortisone injection to the shoulder and medications. Her symptoms included left knee pain rated 7/10 and left shoulder pain rated 9/10. Physical examination of the left knee revealed tenderness over the patella and medial joint line, positive patellar crepitation, and decreased range of motion. Physical examination of the left shoulder revealed positive tenderness over the acromioclavicular joint, decreased range of motion, and significant pain with range of motion. She also had decreased motor strength to 4/5 in the left shoulder. The treatment plan included proceeding with a left knee chondroplasty of all 3 compartments with postoperative physical therapy and durable medical equipment. She was also recommended for left shoulder surgery to include repair of the rotator cuff and SLAP lesion, as well as postoperative physical therapy and durable medical equipment. Requests were received for a CPM 30 day rental, cold therapy unit for 35 days rental, and SurgiStim unit 30 day rental. It was noted that the SurgiStim unit was recommended to provide electrical and muscle stimulation to decrease pain, prevent atrophy, and decrease swelling. The CPM machine (continuous passive motion) was recommended as it is a widely accepted form of treatment following joint surgery. It was noted that the provider felt a shoulder CPM machine is medically necessary and warranted as it will increase range of motion while decreasing pain and swelling.

In regard to the continuous cold therapy unit, this product was recommended as these units have been proven to decrease pain, inflammation, swelling, and narcotic usage after surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continuous Passive Motion (30-day rental): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Knee and Leg Procedure Summary, Continuous Passive Motion Devices.

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: According to the Official Disability Guidelines, continuous passive motion is not recommended for shoulder rotator cuff problems but may be an option for patients with adhesive capsulitis. The clinical information submitted for review indicated that the injured worker was recommended for a shoulder surgery with postoperative use of a CPM machine. While the guidelines do recommend this treatment for patients with active adhesive capsulitis, the guidelines do not support postoperative use at this time. Additionally, the request as submitted did not specify the body region recommended for treatment. For these reasons, the request is not medically necessary.

Q-Tech Recovery System (Cold Therapy Unit - 35-day rental): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Knee and Leg Procedure Summary, 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: According to the Official Disability Guidelines, continuous flow cryotherapy is recommended for up to 7 days postoperatively. The clinical information submitted for review indicated that the injured worker was recommended for left knee and left shoulder surgery followed by use of a cold therapy unit. However, the guidelines only support use of this type of treatment for up to 7 days. Therefore, a 35 day rental is not supported. In addition, the request as submitted did not indicate the body part being recommended for treatment with this device.

SurgiStim Unit (30-day rental): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary, Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, post-operative pain (transcutaneous electrical nerve stimulation), Neuromuscular electrical stimulation (NMES devices) Page(s): 116-117,121.

Decision rationale: According to the California MTUS Guidelines, postoperative use of a TENS unit is recommended in the first 30 days postsurgery. However, the guidelines state neuromuscular electrical stimulation is not recommended for chronic pain and is only recommended as a part of a rehabilitation program following stroke. While use of a TENS unit would be supported postoperatively, the combination unit with neuromuscular electrical stimulation is not supported. Therefore, the request for a SurgiStem unit is not supported by the evidence based guidelines. In addition, the request as submitted did not indicate the body parts being recommended for treatment with this device. As such, the request is not medically necessary.