

Case Number:	CM14-0048290		
Date Assigned:	07/02/2014	Date of Injury:	09/17/2012
Decision Date:	11/19/2015	UR Denial Date:	04/12/2014
Priority:	Standard	Application Received:	04/16/2014

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:

This injured worker is a 48 year old male, who sustained an industrial injury on 09-17-2012. The injured worker was diagnosed as having right shoulder chronic subacromial impingement syndrome - status post right shoulder sprain-strain injury. On medical records dated 03-14-2014, the subjective complaints were noted as right shoulder pain. Pain was rated an 8 out of 10. Objective findings were noted as a decreased range of motion, positive AC joint compression test and positive impingement signs were noted. Treatments to date included physiotherapy, cortisone injections, home exercise, home cryotherapy, acupuncture and medication. The provider recommended surgical intervention and post-operative continuous passive motion device for an initial 45 days use to assist with restoring range of motion and [REDACTED] cold therapy unit, and Surgi-Stim 90 day unit for swelling, edema and pain. Current medications were listed as Ultram and Robaxin on 04-08-2014. The Utilization Review (UR) was dated 04-12-2014. A Request for Authorization was dated 03-14-2014 for continuous passive motion device for an initial 45 days use, [REDACTED] cold therapy unit, and Surgi-Stim 90 day unit use was submitted. The UR submitted for this medical review indicated that the request for continuous passive motion device for an initial 45 days use, [REDACTED] cold therapy unit, and Surgi-Stim 90 day unit use was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continuous passive motion device for an initial 45 days use: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic).

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

Decision rationale: The current request is for Continuous passive motion device for an initial 45 days use. The RFA is dated 04/08/14. Treatments to date included TENS, physiotherapy, cortisone injections, home exercise, home cryotherapy, acupuncture and medication. The patient is not working. ACOEM and MTUS do not discuss Continuous passive motion devices. ODG, Shoulder Chapter under Continuous passive motion devices (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." ODG further states, "Rotator cuff tears: Not recommended after shoulder surgery or for nonsurgical treatment." Per report 03/14/14, the patient presents with significant right shoulder pain, and has failed conservative treatments. Pain was rated an 8 out of 10. Objective findings noted a decreased range of motion, positive AC joint compression test and positive impingement sign. The treater recommended surgery, post op PT, CPM device, cold therapy unit and a Surgistim unit. Records show that the patient was authorized for a right arthroscopic shoulder decompression, distal clavicle resection and labral and/or rotator cuff debridement and repair on 04/09/14. This is a retro request for a CPM device for 45 days following the shoulder surgery. ODG does not recommend CPM for rotator cuff tears. ODG Guidelines does recommend CPM devices for patients with adhesive capsulitis, which the patient does not present with. Furthermore, ODG recommends using the unit for 4 weeks/5 days per week, and the current request is for 45 days, which exceeds what is allowed by ODG. The request is not medically necessary.

████████ 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- Cold compression therapy.

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

Decision rationale: The current request is for ██████████ Cold Therapy Unit. The RFA is dated 04/08/14. Treatments to date included TENS, physiotherapy, cortisone injections, home exercise, home cryotherapy, acupuncture and medication. The patient is not working. ODG, Shoulder 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." ODG, Knee & Leg Chapter under Continuous-flow cryotherapy states: "recommended as an option after surgery for up to 7 days including home use." Per report 03/14/14, the patient presents with significant right shoulder pain, and has failed conservative treatments. Pain was rated an 8 out of 10. Objective findings noted a decreased range of motion, positive AC joint compression test and positive impingement sign. The treater recommended surgery, post op PT, CPM device, cold therapy unit and a Surgistim unit. Records show that the patient was authorized for a right arthroscopic shoulder decompression, distal clavicle resection and labral and/or rotator cuff debridement and repair on 04/09/14. This is a retro request for a cold therapy unit. Cold therapy units are supported for post-operative use; however, the request as stated does not specify duration of use. Guidelines support the use of the unit for up to 7 days postoperatively, and this request is for the unit without specifying duration of use. Therefore, the request IS NOT medically necessary.

Surgi-Stim 90 day unit use: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The current request is for Surgi-Stim 90 Day Unit. The RFA is dated 04/08/14. Treatments to date included TENS, physiotherapy, cortisone injections, home exercise, home cryotherapy, acupuncture and medication. The patient is not working. MTUS pages 118 to 120, Interferential Current Stimulation (ICS) Section states: "not recommended as an isolated intervention." MTUS further states, "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway. It may be appropriate if pain is not effectively controlled due to diminished effectiveness or side effects of medication; history of substance abuse, significant pain due to postoperative conditions; or the patient is unresponsive to conservative measures. A one month trial may be appropriate if the above criteria are met." MTUS Guidelines recommend such treatment modalities when "pain is not effectively controlled due to diminished effectiveness or side effects of medication; history of substance abuse, significant pain due to postoperative conditions; or the patient is unresponsive to conservative measures." There is no such discussion provided in conjunction with this request. Furthermore, the request is for 90 days and MTUS recommends a 30-day trial period. The request is not within MTUS guidelines. Therefore, the request IS NOT medically necessary.