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| Case Number: | CM15-0000422 | | |
| Date Assigned: | 01/12/2015 | Date of Injury: | 11/04/2010 |
| Decision Date: | 03/12/2015 | UR Denial Date: | 12/24/2014 |
| Priority: | Standard | Application Received: | 01/02/2015 |

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:

The injured worker (IW) is a 55 year old male, who sustained an industrial injury on 11/4/2010, and again on June 23, 2012. He has reported improvement of the right shoulder and worsened pain in the left shoulder with activity or rest and was diagnosed with right shoulder, large rotator cuff tear, resolving impingement syndrome of the right shoulder and symptomatic rotator cuff tear, impingement syndrome and distal clavicle arthrosis of the left shoulder. Treatment to date has included pain medications, diagnostic studies, radiographic imaging, physical therapy, and surgical consultation. Currently, the IW complains of pain in the left shoulder during the day and night. The IW sustained a work related injury on 11/4/2010 and on 6/23/2012. He reported experiencing pain in the right shoulder. Magnetic resonance imaging (MRI) of the right shoulder revealed a large retracted tear. Arthroscopic right shoulder rotator cuff repair noted to be difficult was performed on 6/1/2011. Pain became worse after the surgical procedure. Physical therapy was initiated as well as a home exercise plan. MRIs were completed on 5/23/2012, 8/9/2012, and 7/5/2013 revealing no re-tear of the rotator cuff however abnormalities were noted including bursitis and tendinosis. He continued to treat the pain with pain medications, a home exercise plan, and restricted activity. By September of 2013, the IW complained of worsening left shoulder pain secondary for compensating for the right shoulder injury. On January 9, 2014, the IW underwent a right shoulder arthroscopic rotator cuff repair. Improvements were noted in the right shoulder following surgical correction and physical therapy. MRI of the left shoulder on 11/6/2014, revealed a full-thickness tear and degenerative arthrosis. Surgical repair of the left shoulder was recommended for 11/12/2014. On December 24, 2014, Utilization Review non-

certified a thermacooler (E1399) for 30 days, interferential unit (E0745) for 30 days and a CPM unit (E0936) for 30 days noting the MTUS, ACOEM Guidelines, (or ODG) was cited.) On January 2, 2015, the injured worker submitted an application for IMR for review of requests for a thermacooler (E1399) for 30 days, an interferential unit (E0745) for 30 days, and a CPM unit (E0936) for 30 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

Thermacooler E1399 for 30 days;: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203, 212. Decision based on Non-MTUS Citation Shoulder (Acute & Chronic)

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses cold therapy. American College of Occupational and Environmental Medicine (ACOEM) Chapter 9 Shoulder Complaints states that at-home applications of cold packs may be used before or after exercises. Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) indicate that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. The orthopedic report dated November 12, 2014 documented a recommendation for arthroscopic rotator cuff repair surgery. Per ODG, post-operative use of a cryotherapy appliance is limited to 7 days. Thus, the request for 30 day use of a Thermacooler device is not supported by ODG guidelines. Therefore, the request for Thermacooler for 30 days is not medically necessary.

Interferential Unit E0745 for 30 days: Upheld

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

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 shoulder conditions. Interferential home stimulation 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 interferential unit is not medically necessary.

CPM Unit R0936 for 30 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder

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

Decision rationale: Medical Treatment Utilization Schedule (MTUS) does not address continuous passive motion (CPM). Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) indicates that continuous passive motion (CPM) is not recommended for shoulder rotator cuff problems. For rotator cuff tears, continuous passive motion devices are not recommended after shoulder surgery or for nonsurgical treatment. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain, and one study found no difference in range of motion or strength. The orthopedic report dated November 12, 2014 documented a recommendation for arthroscopic rotator cuff repair surgery. Official Disability Guidelines (ODG) do not support the use of continuous passive motion (CPM). Therefore, the request for a CPM unit is not medically necessary.