

Case Number:	CM15-0017613		
Date Assigned:	02/05/2015	Date of Injury:	04/24/2013
Decision Date:	04/13/2015	UR Denial Date:	01/14/2015
Priority:	Standard	Application Received:	01/29/2015

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: Orthopedic Surgery

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 46 year old male, who sustained an industrial injury on 4/24/2013. The diagnoses have included cervical sprain/strain, cervicgia, displacement of cervical intervertebral disc without myelopathy, cervical spinal stenosis, left shoulder sprain, disorder of the bursa and tendons shoulder region and brachial neuritis. Treatment to date has included activity modification, physical therapy and injections. Magnetic resonance imaging (MRI) of the left shoulder dated 2/05/2014 showed acromion flat and laterally down sloping: Acromioclavicular (AC) joint, Osteoarthritis (OA) and supraspinatus and infraspinatus tendinosis. Per the treating physician note on 4/24/13, there is fluid in the subacromial bursa and signal changes to the rotator cuff. Currently, the IW complains of continued persistent neck pain and left shoulder pain. He is scheduled to see a pain management specialist and EMG (electromyography)/NCV (nerve conduction studies). Objective findings included atrophy of the left supraspinatus. Range of motion is restricted. Hawk's and Neer test are positive. There is tenderness at the AC joint with positive anterior and posterior AC joint stress test. The strength is decreased in scapular abduction and external rotation. On 1/14/2015, Utilization Review non-certified a request for CPM unit and IF unit and modified a request for a 30 day rental of a ThermoCooler noting that the clinical findings do not support the medical necessity of the treatment. The ACOEM Guidelines were cited. On 1/29/2015, the injured worker submitted an application for IMR for review of CPM unit, IF unit and ThermoCooler.

IMR ISSUES, DECISIONS AND RATIONALES

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

continuous passive motion unit (CPM) Unit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, CPM.

Decision rationale: CA MTUS/ACOEM guidelines are silent on the issue of CPM machine. According to the Official Disability Guidelines, Shoulder Chapter, Continuous passive motion (CPM), CPM is recommended for patients with adhesive capsulitis but not with patients with rotator cuff pathology primarily. With regards to adhesive capsulitis it is recommended for 4 weeks. As there is no evidence preoperatively of adhesive capsulitis in the exam note of 4/24/13, the determination is for non-certification.

30 days TheraCooler: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, and Continuous flow cryotherapy.

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case, there the recommendation exceeds the guidelines recommendation of 7 days. Therefore, the determination is for non-certification.

30 days Interferential (IF) unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation, pages 118-119.

Decision rationale: Regarding the Interferential Current Stimulation (ICS), the California MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation, pages 118-119 state, Not recommended as an isolated intervention. There is no quality 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. 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-interpretable for recommendation due to poor study design and/or methodologic issues. As there is insufficient medical evidence from the exam note of 4/24/13 regarding use in this clinical scenario, the determination is for non-certification.