

Case Number:	CM15-0138471		
Date Assigned:	07/28/2015	Date of Injury:	08/21/2012
Decision Date:	10/15/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/16/2015

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: Texas, California

Certification(s)/Specialty: Family Practice

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 54 year old male who sustained an industrial injury on 08-21-12. Initial complaints and diagnoses are not available. Treatments to date include medications, physiotherapy, home cryotherapy, activity restrictions. Diagnostic studies include MRI studies of the left shoulder. Current complaints include pain in the left shoulder on 5/29/15. Physical examination of the left shoulder revealed tenderness on palpation, positive AC compression and impingement test. Current diagnoses include left shoulder impingement syndrome with acromioclavicular joint degenerative joint disease status post industrial left shoulder sprain and strain injury. In a progress note dated 05-29-15 the treating provider reports the plan of care as shoulder surgery with associated E-stimulator, cold therapy unit rental, deep vein thrombosis compression unit rental, and continuous passive motion machine rental. The requested treatments include E-stimulator, cold therapy unit rental, deep vein thrombosis compression unit rental, and continuous passive motion machine rental. The patient's surgical history include left shoulder arthroscopy on 7/29/15. A detailed physical examination of the left shoulder following surgery was not specified in the records specified. The details of post surgical treatment were not specified in the records specified. The patient had received an unspecified number of PT visits for this injury. The patient had used home cryotherapy for this injury. The medication list include Naproxen.

IMR ISSUES, DECISIONS AND RATIONALES

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

E-stim: Upheld

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

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

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation (ICS) is "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." Per the cited guideline "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/ physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.) If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction." According the cited guidelines, electrical stimulation (TENS), is "not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Recommendations by types of pain: A home-based treatment trial of one month may be appropriate for neuropathic pain and CRPS II (conditions that have limited published evidence for the use of TENS as noted below), and for CRPS I (with basically no literature to support use)." According the cited guidelines, Criteria for the use of TENS is "There is evidence that other appropriate pain modalities have been tried (including medication) and failed. A treatment plan including the specific short and long-term goals of treatment with the TENS unit should be submitted." A detailed physical examination of the left shoulder following surgery was not specified in the records specified. The details of post surgical treatment were not specified in the records specified. Evidence of neuropathic pain, CRPS I and CRPS II was not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. A response to complete course of conservative therapy including PT visits was not specified in the records provided. Prior conservative therapy visit notes were not specified in the records provided. Evidence of a trial and failure of a TENS unit for this injury was not specified in the records provided. In addition a treatment plan including the specific short- and long-term goals of treatment with the TENS unit was not specified in the records provided. The response of the symptoms to a period of rest, oral pharmacotherapy is not specified in the records provided the records provided did not specify any recent physical therapy with active PT modalities or a plan to use TENS as an adjunct to a program of evidence-based functional restoration. Evidence of diminished effectiveness of medications or intolerance to medications

or history of substance abuse was not specified in the records provided. The medical necessity of the request for E-stim is not fully established for this patient and therefore is not medically necessary.

Cold therapy unit rental for 90 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 Shoulder Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (updated 09/08/15) Continuous-flow cryotherapy.

Decision rationale: Per the cited guidelines "Patients at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist". Rationale for not using simple hot/cold packs versus the use of this DME is not specified in the records provided. As per cited guideline, "Continuous-flow cryotherapy: Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use". The rationale for requesting the cold therapy unit for 90 days was not specified in the records provided. A recent detailed clinical evaluation note of treating physician was not specified in the records. A detailed physical examination of the left shoulder following surgery was not specified in the records specified. The details of post surgical treatment were not specified in the records specified. Patient has received an unspecified number of PT visits for this injury. Detailed response to previous conservative therapy was not specified in the records provided. Evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The medical necessity of the request for Cold therapy unit rental for 90 days is not fully established in this patient and therefore is not medically necessary.

Deep venous thrombosis (DVT) compression unit rental for 45 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute, ODG Treatment in Workers compensation - updated 8/22/12.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (updated 09/08/15) Cold compression therapy compression garments Forearm, Wrist, & Hand (updated 06/29/15) Vasopneumatic devices.

Decision rationale: ACOEM and CA MTUS chronic pain guidelines do not address this request. Therefore ODG was used. Per the cited guidelines, cold compression therapy is, "Not recommended in the shoulder, as there are no published studies." Per the cited guidelines for compression garments, "Not generally recommended in the shoulder. Deep venous thrombosis and pulmonary embolism events are common complications following lower-extremity orthopedic surgery, but they are rare following upper-extremity surgery, especially shoulder arthroscopy. It is still recommended to perform a thorough preoperative workup to uncover possible risk factors for deep venous thrombosis/ pulmonary embolism despite the rare occurrence of developing a pulmonary embolism following shoulder surgery. Mechanical or chemical prophylaxis should be administered for patients with identified coagulopathic risk factors." The presence of identified coagulopathic risk factors in this patient were not specified

in the records provided. Per the cited guidelines vasopneumatic device is "Recommended as an option to reduce edema after acute injury." As per cited guidelines "There is inconsistent evidence for compression stockings to prevent post-thrombotic syndrome (PTS) after first-time proximal deep venous thrombosis (DVT). The findings of this study do not support routine wearing of elastic compression stockings (ECS) after DVT." Evidence of edema was not specified in the records provided. A detailed physical examination of the left shoulder following surgery was not specified in the records specified. The details of post surgical treatment were not specified in the records specified. The details of PT or other types of therapy done since the date of injury were not specified in the records provided. Evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The medical necessity of the request for Deep venous thrombosis (DVT) compression unit rental for 45 days is not fully established in this patient and therefore is not medically necessary.

Continuous passive motion (CPM) unit rental for 45 days: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (updated 09/08/15) Continuous passive motion (CPM).

Decision rationale: ACOEM and CA MTUS chronic pain guidelines do not address this request. Therefore ODG was used. As per cited guideline, "Continuous passive motion (CPM): Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Rotator cuff tears: Not recommended after shoulder surgery or for nonsurgical treatment." A detailed physical examination of the left shoulder following the surgery was not specified in the records specified. The presence of adhesive capsulitis was not specified in the records provided. The details of post surgical treatment were not specified in the records specified. Patient has received an unspecified number of PT visits for this injury. Detailed response to previous conservative therapy was not specified in the records provided. The medical necessity of the request for Continuous passive motion (CPM) unit rental for 45 days is not fully established for this patient and therefore is not medically necessary.