

Case Number:	CM15-0201689		
Date Assigned:	10/16/2015	Date of Injury:	06/15/2010
Decision Date:	12/29/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	10/13/2015

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: Minnesota, Florida
 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 56 year old female who sustained an industrial injury on 6-15-10. The impression is noted as partial thickness right rotator cuff tear, chronic subacromial impingement and adhesive capsulitis. Subjective complaints (7-6-15) include right shoulder pain rated 10 out of 10. Objective findings (7-6-15) include right shoulder decreased range of motion and (8-5-15) shoulder tenderness to palpation, positive impingement test, and positive cross arm test. Diagnostic ultrasound right shoulder is noted to reveal 75 percent partial thickness rotator cuff tear with subacromial impingement syndrome. Previous treatment includes physical therapy, Cortisone injections, and medication. Athroscopic right shoulder surgery was approved. On 9-16-15, the requested treatment of associated surgical service (right shoulder): continuous passive motion device for 45 days was modified to 20 days, surgi stim electrical stimulation unit 90 days was denied, cold therapy unit 90 days was modified to 7 days, and post-operative immobilizer with abduction pillow was denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Continuous passive motion device for right shoulder, 45 days:
 Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Continuous passive motion.

Decision rationale: The available documentation suggests that the injured worker has adhesive capsulitis of the shoulder. ODG guidelines recommend postoperative use of continuous passive motion for adhesive capsulitis of the shoulder for up to 20 days. The request as stated is for 45 days which is not supported by guidelines and as such, the medical necessity of the request has not been substantiated. Therefore the request is not medically necessary.

Associated surgical service: Surgi stim electrical stimulation unit, right shoulder, 90 days: Upheld

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

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

Decision rationale: Surgi Stim is a combination of neuromuscular stimulation, H-wave stimulation, and interferential electrical stimulation. California MTUS chronic pain guidelines do not recommend neuromuscular stimulation except after a stroke. H-wave stimulation and interferential stimulation are also not recommended. As such, the medical necessity of the request for a Surgi Stim rental for 90 days is not supported. Therefore the request is not medically necessary.

Associated surgical service: Cold therapy unit for right shoulder, 90 days: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Continuous flow cryotherapy.

Decision rationale: With regard to the request for cold therapy, ODG guidelines recommend continuous-flow cryotherapy as an option after shoulder surgery for 7 days. Use beyond 7 days is not recommended. The request as stated is for 90 days which is not supported and the medical necessity of the request has not been substantiated. Therefore the request is not medically necessary.

Post op immobilizer with abduction pillow, right shoulder: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Postoperative abduction pillow sling.

Decision rationale: ODG guidelines recommend postoperative abduction pillow slings for open repairs of large and massive rotator cuff tears. It takes the tension off of the repair. In this case, the injured worker does not have a large or massive rotator cuff tear and an open repair is not being performed. As such, the medical necessity of the postoperative immobilizer with abduction pillow has not been substantiated. Therefore the request is not medically necessary.