

Case Number:	CM15-0209626		
Date Assigned:	10/28/2015	Date of Injury:	12/17/2013
Decision Date:	12/09/2015	UR Denial Date:	10/06/2015
Priority:	Standard	Application Received:	10/24/2015

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: 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:

The injured worker was a 51 year old, right handed male, who sustained an industrial injury, December 17, 2013. The injured worker was undergoing treatment for right shoulder impingement syndrome, right rotator cuff high-grade partial thickness tear of the supraspinatus, chronic subacromial impingement and acromioclavicular degenerative joint disease. According to progress note of September 17, 2015, the injured worker's chief complaint was right shoulder pain. The pain was rated at 7 out of 10. The physical exam noted positive impingement syndrome. On September 17, 2015, the injured worker complained of right shoulder pain with loss of motion. There was decreased range of motion in all planes. There was severe supraspinous tenderness. There was moderate tenderness AC joint and greater tuberosity tenderness along with mild Biceps tendon tenderness. The muscle strength was decreased with forward flexion, abduction, external rotation and internal rotation. The impingement testing, AC compression testing and abduction testing were positive. The injured worker had a surgical consultation who recommended surgery. The injured worker previously received the following treatments Diclofenac, Voltaren XR, Flexmid, Colace, right shoulder MRI which showed a partial tear of the supraspinatus, acromioclavicular degenerative joint degenerative joint disease and impingement syndrome. The RFA (request for authorization) dated the following treatments were requested motion (CPM) device, shoulder immobilizer with abduction pillow, surgical stimulator unit and cool care cold therapy unit for postoperative care. The UR (utilization review board) denied certification on October 6, 2015; for the home continuous passive range of motion (CPM) device, shoulder immobilizer with abduction pillow, surgical stimulator unit and cool care cold therapy unit, which was modified for a seven day rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home continuous passive motion (CPM) device: 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, Continuous Passive Motion (CPM), page 910.

Decision rationale: Although ODG does recommend CPM for post knee surgery with restricted indications, it specifically states the CPM is not recommended for post shoulder surgeries as multiple studies have note no difference in function, pain, strength or range of motion. Submitted reports have not demonstrated adequate support for the continuous passive motion unit post shoulder arthroscopy outside the recommendations of the guidelines. The Home continuous passive motion (CPM) device is not medically necessary and appropriate.

Shoulder immobilizer with abduction pillow: 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, Immobilization, page 920; Post-operative Abduction Pillow Sling, page 933.

Decision rationale: Per Guidelines, a shoulder immobilizer with abduction pillow may be recommended as an option following open repair of large and massive open rotator cuff tears; AC separation; brief use of immobilization for severe shoulder pain up to 1-2 days; and for use less than few weeks after initial shoulder dislocation with reduction; however, submitted reports have not adequately demonstrated any such criteria. Guidelines state that immobilization with prolonged periods of rest are generally less effective than having patients maintain their usual pre-injury activities. Medical indication and necessity has not been established and criteria are not met. Additionally, the Official Disability Guidelines also state that postoperative abduction pillows are only recommended as an option following an open repair of large or massive rotator cuff tears, not indicated here. Abduction pillows for large or massive tears may decrease tendon contact to the prepared sulcus, but are not recommended for arthroscopic repairs by guideline recommendations. Submitted reports have not demonstrated the medical necessity outside the recommendations of Guidelines criteria. The Shoulder immobilizer with abduction pillow is not medically necessary and appropriate.

Surgi Stim unit: Upheld

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

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

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of Surgistim Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. It appears the patient has received extensive conservative treatment to include medications, therapy modalities, and rest; however, functional status and pain relief remain unchanged. Guidelines do not recommend Surgistim unit for post-op care of rotator cuff repair. There is no documented short-term or long-term goals of treatment with the Surgistim unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief as part of the functional restoration approach to support the request for the Stim Unit for unknown rental duration or purchase. There is also no report of post-op complications or extenuating circumstances to support for the surgistim unit without documented goals and functional assessment outside guidelines recommendation for 30-day trial. The Surgi Stim unit is not medically necessary and appropriate.