

Case Number:	CM15-0212107		
Date Assigned:	10/30/2015	Date of Injury:	12/13/2012
Decision Date:	12/15/2015	UR Denial Date:	10/01/2015
Priority:	Standard	Application Received:	10/28/2015

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: Illinois, California, Texas
 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:

This injured worker is a 57-year-old female who sustained an industrial injury on 12/13/12, relative to continuous trauma. Conservative treatment had included activity modification, medications, physical therapy, and corticosteroid injection. The 2/10/15 right shoulder ultrasound showed a partial thickness supraspinatus tear, subacromial impingement, partial tear of the supraspinatus tendon, and longitudinal split tear within the long head of the biceps tendon. Records indicated that the injured worker underwent a right shoulder corticosteroid injection on 5/26/15 with significant improvement in symptoms for 2 weeks. She had persistent functional difficulty in activities of daily living. The 7/6/15 treating physician report cited on-going right shoulder pain despite aggressive conservative treatment and time. Physical exam documented acromioclavicular joint tenderness, subacromial crepitus, 4/5 global right shoulder weakness, and positive impingement tests. Right shoulder range of motion testing documented forward flexion 160, extension 40, abduction 160, adduction 40, external rotation 90, and internal rotation 60 degrees. The diagnosis included right shoulder partial thickness rotator cuff tear, subacromial impingement, and longitudinal split tear within the long head of the biceps tendon. The treatment plan included right shoulder arthroscopic decompression, distal clavicle resection, rotator cuff debridement and/or repair. Authorization was also requested for home continuous passive motion (CPM) device for 45 days, Surgi-Stim unit for 90 days, and Coolcare cold therapy unit. The 10/1/15 utilization review certified the request for right shoulder arthroscopic decompression, distal clavicle resection, and rotator cuff debridement and/or repair. The request for a CPM unit was non-certified as guidelines do not support the use of a CPM unit following

rotator cuff repair. The request for a Surgi-Stim unit for 90 days was modified to a TENS unit for 30 days consistent with MTUS Transcutaneous Electrotherapy guidelines for post-operative care. The request for a Coolcare cold therapy unit was modified to a cold therapy unit rental for 7 days consistent with the Official Disability Guidelines.

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 for 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 (ODG).

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

Decision rationale: The California MTUS does not provide recommendations for continuous passive motion (CPM) following shoulder surgery. The Official Disability Guidelines state that CPM is recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Guidelines state that CPM is not recommended after rotator cuff shoulder surgery. Guideline criteria have not been met. This injured worker presents with persistent and function-limiting right shoulder pain. She has been certified for a right shoulder arthroscopic decompression, distal clavicle resection, and rotator cuff repair. Pre-operative range of motion testing does not evidence adhesive capsulitis. The routine use of a CPM unit following rotator cuff surgery is not supported by guidelines. There is no compelling rationale to support the medical necessity of this request as an exception to guidelines. Therefore, this request is not medically necessary.

Surgi-Stim Unit for 90 days: 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: The Surgi Stim unit provides a combination of interferential current, neuromuscular electrical stimulation (NMES), galvanic current, and (direct) pulsed current. The California MTUS guidelines for transcutaneous electrotherapy do not recommend the use of NMES or galvanic stimulation in the treatment of chronic pain or post-operative care. Galvanic stimulation is considered investigational for all indications. Guidelines suggest that interferential current is not recommended as an isolated intervention. Guidelines support limited use of TENS unit in the post-operative period for up to 30 days. Guideline criteria have not been met for the Surgi-Stim unit. If one or more of the individual modalities provided by this multi-modality unit is not supported, then the unit as a whole is not supported. The 10/1/15 utilization review modified this request to a 30-day rental of a TENS unit which is supported in the post-

operative period by guidelines. There is no compelling rationale to support the medical necessity of this request as an exception to guidelines. Therefore, this request is not medically necessary.

Coolcare Cold therapy Unit: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)
Shoulder: continuous flow cryotherapy.

Decision rationale: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. The 10/1/15 utilization review decision recommended partial certification of this cold therapy device for 7-day use. There is no compelling reason in the records reviewed to support the medical necessity of a cold device beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.