

Case Number:	CM15-0040737		
Date Assigned:	03/10/2015	Date of Injury:	06/14/2010
Decision Date:	04/20/2015	UR Denial Date:	03/02/2015
Priority:	Standard	Application Received:	03/03/2015

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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 42 year old male sustained a work related injury on 06/14/2010. According to a progress report dated 02/14/2015, the injured worker continued to be symptomatic with right knee and shoulder pain. The left knee was better status post-surgery. The provider made reference to diagnoses from a another provider which included fractured pelvis, partial-thickness tear of right rotator cuff, herniated lumbar disc, industrial right meniscus tear, industrial left meniscus tear and status post scope. Objective findings included range of motion of the shoulder was restricted with painful arc. Provocative testing was positive. There was tenderness of the lumbar spine. He had difficulty squatting and kneeling. McMurray's test was positive on the right. Diagnoses included status post left knee scope, lumbar strain, right shoulder impingement and right knee derangement. The injured worker wanted to proceed with right shoulder surgery. If authorized, approval was needed for shoulder scope, decompression and repair. According to the provider, the injured worker could not be made permanent and stationary because the Qualified Medical Examiner recommended surgery for his shoulder and knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit purchase for the 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 (ODG), Shoulder chapter, Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cold/heat packs.?(http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#SPECT).

Decision rationale: According to ODG guidelines, cold therapy is “Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007) See also Heat therapy; Biofreeze cryotherapy gel.” There is no controlled studies supporting the use of hot/cold therapy in post op pain beyond 7 days after surgery. There is no documentation that the patient's surgery request has been approved. Therefore, the request for Cold therapy unit purchase for the right shoulder is not medically necessary.

Interferential unit purchase for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

Decision rationale: According to MTUS guidelines, Interferential Current Stimulation (ICS). 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. (Van der Heijden, 1999)(Werner, 1999) (Hurley, 2001) (Hou, 2002) (Jarit, 2003) (Hurley, 2004) (CTAF, 2005)(Burch, 2008) The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. 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.)."There is no clear evidence that the neurostimulator will be used as a part of a rehabilitation program. In addition, there is no documentation of post op pain that will limit the patient's ability to perform physical therapy since there is no documentation on the surgery's request decision. Therefore, the request for Interferential unit purchase for the right shoulder is not medically necessary.

3 month supply of electrodes for the Interferential unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

Decision rationale: Since the interferential stimulator is not certified, the electrodes are not medically necessary.

Shoulder exercise kit: 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), page 98.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Medical Treatment Guidelines Exercise Page(s): 46-47.

Decision rationale: According to MTUS guidelines, an exercise program is recommended. "There is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. A therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated. Such programs should emphasize education, independence, and the importance of an on-going exercise regime."There is no documentation of disabling pain. The request does not address who will be monitoring the patient functional improvement. In addition, there is no documentation concerning the surgery's request. Therefore, the request for Shoulder exercise kit is not medically necessary.