

Case Number:	CM15-0050610		
Date Assigned:	03/24/2015	Date of Injury:	07/25/2002
Decision Date:	05/01/2015	UR Denial Date:	02/19/2015
Priority:	Standard	Application Received:	03/17/2015

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, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational 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:

The injured worker is a 72 year old, male, who sustained a work related injury on 7/25/02. The diagnoses have included persistent symptomatic recurrent rotator cuff tear, impingement syndrome and distal clavicle arthrosis. Treatments have included medications, physical therapy, a subacromial cortisone injection left shoulder, MR Arthrogram left shoulder on 6/25/14 and left shoulder surgery on 1/27/15. In the PR-2 dated 10/20/14, the injured worker complains of left shoulder pain that is made worse by lifting, reaching and pushing activities. He has pain during the day and night. There is some decreased range of motion in left shoulder. The treatment plan is to recommend left shoulder surgery. No medical records found that note requested treatments of a inferential unit, cold therapy machine, a continuous passive motion machine, a shoulder wrap and a sheepskin pad.

IMR ISSUES, DECISIONS AND RATIONALES

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

One IF unit purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 116 of 127. Decision based on Non-MTUS Citation ODG Low Back, under Interferential Stimulators.

Decision rationale: The injury is 13 years ago. No medical records were located to state why this care was needed. The MTUS notes that electrical stimulators like interferential units are not recommended as a primary treatment modality, but a one-month home-based 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. Neuropathic pain: Some evidence (Chong, 2003), including diabetic neuropathy (Spruce, 2002) and post-herpetic neuralgia. (Niv, 2005) Phantom limb pain and CRPS II: Some evidence to support use. (Finsen, 1988) (Lundeberg, 1985)- Spasticity: may be a supplement to medical treatment in the management of spasticity in spinal cord injury. (Aydin, 2005) Multiple sclerosis (MS): While electrical stimulators do not appear to be effective in reducing spasticity in MS patients it may be useful in treating MS patients with pain and muscle spasm. (Miller, 2007) Further, regarding interferential stimulators for the low back, the ODG notes: Not generally recommended. 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. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. Interferential current works in a similar fashion as TENS, but at a substantially higher frequency (4000-4200 Hz). See the Pain Chapter for more information and references. See also Sympathetic therapy. In this case, the stimulator is not generally recommended due to negative efficacy studies, and the claimant does not have conditions for which electrical stimulation therapies might be beneficial. The request is appropriately non-certified and not medically necessary.

Unknown electrodes: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 116 of 127. Decision based on Non-MTUS Citation ODG Low Back, under Interferential Stimulators.

Decision rationale: The unit for which these electrodes would be used was non-certified. The MTUS notes that electrical stimulators like interferential units are not recommended as a primary treatment modality, but a one-month home-based 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. Neuropathic pain: Some evidence (Chong, 2003), including diabetic neuropathy (Spruce, 2002) and post-herpetic neuralgia. (Niv, 2005) Phantom limb pain and CRPS II: Some evidence to support use. (Finsen, 1988) (Lundeberg, 1985) Spasticity: may be a supplement to medical treatment in the management of spasticity in spinal cord injury. (Aydin, 2005) Multiple sclerosis (MS): While electrical stimulators do not appear to be effective in reducing spasticity in MS patients it may be useful in treating MS patients with pain and muscle spasm. (Miller, 2007) Further, regarding interferential stimulators for the low back,

the ODG notes: Not generally recommended. 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. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. Interferential current works in a similar fashion as TENS, but at a substantially higher frequency (4000-4200 Hz). See the Pain Chapter for more information and references. See also Sympathetic therapy. In this case, the stimulator is not generally recommended due to negative efficacy studies, and the claimant does not have conditions for which electrical stimulation therapies might be beneficial. As the unit itself was non-certified, the need for the electrodes and lead wires is likewise unnecessary. The request is appropriately non-certified and not medically necessary.

Unknown lead wires: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 116 of 127. Decision based on Non-MTUS Citation ODG Low Back, under Interferential Stimulators.

Decision rationale: The MTUS notes that electrical stimulators like interferential units are not recommended as a primary treatment modality, but a one-month home-based 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. Neuropathic pain: Some evidence (Chong, 2003), including diabetic neuropathy (Spruce, 2002) and post-herpetic neuralgia. (Niv, 2005) Phantom limb pain and CRPS II: Some evidence to support use. (Finsen, 1988) (Lundeberg, 1985) Spasticity: may be a supplement to medical treatment in the management of spasticity in spinal cord injury. (Aydin, 2005) Multiple sclerosis (MS): While electrical stimulators do not appear to be effective in reducing spasticity in MS patients it may be useful in treating MS patients with pain and muscle spasm. (Miller, 2007) Further, regarding interferential stimulators for the low back, the ODG notes: Not generally recommended. 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. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. Interferential current works in a similar fashion as TENS, but at a substantially higher frequency (4000-4200 Hz). See the Pain Chapter for more information and references. See also Sympathetic therapy. In this case, the stimulator is not generally recommended due to negative efficacy studies, and the claimant does not have conditions for which electrical stimulation therapies might be beneficial. As the unit itself is non-certified, there is no need for lead wires. The request is not medically necessary and therefore, appropriately non-certified.

Thirty (30) day rental of cold pneumatic compression 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), Compression Garments.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48 of ACOEM, under Initial Approach to Treatment notes.

Decision rationale: This is a cold therapy unit. This durable medical equipment item is a device to administer regulated cold. However, the MTUS/ACOEM guides note that "during the acute to subacute phases for a period of 2 weeks or less, physicians can use passive modalities such as application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise. They are most effective when the patient uses them at home several times a day". More elaborate equipment than simple cold packs are simply not needed to administer cold modalities; the guides note it is something a claimant can do at home with simple home old packs made at home, without the need for such equipment. As such, this DME would be superfluous and not necessary, and not in accordance with MTUS/ACOEM. The request is not medically necessary and, therefore, was appropriately non-certified.

One (1) shoulder wrap: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48.

Decision rationale: This wrap would accompany the cold therapy unit, which was previously non certified. As shared previously, the MTUS/ACOEM guides note that "during the acute to subacute phases for a period of 2 weeks or less, physicians can use passive modalities such as application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise. They are most effective when the patient uses them at home several times a day". More elaborate equipment than simple cold packs are simply not needed to administer cold modalities; the guides note it is something a claimant can do at home with simple home old packs made at home, without the need for such equipment. As such, this DME would be superfluous and not necessary, and not in accordance with MTUS/ACOEM. The request was appropriately non-certified. As the cold therapy unit is appropriately non-certified, the wrap to accompany the unit would also be not medically necessary & non-certified.

Thirty (30) day rental of CPM 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), Shoulder (Acute & Chronic), Continuous-flow cryotherapy.

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

Decision rationale: The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. Regarding Continuous Passive Motion (CPM) for the Shoulder, the ODG notes in the shoulder section: Not recommended for the shoulder. See the Knee Chapter for more information and Criteria for the use of continuous passive motion devices. (Raab, 1996) (BlueCross BlueShield, 2005) An AHRQ Comparative Effectiveness Review concluded that evidence on the comparative effectiveness and the harms of various operative and nonoperative treatments for rotator cuff tears is limited and inconclusive. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain, and one study found no difference in range of motion or strength. (Seida, 2010) The request is not medically necessary.

One (1) synthetic sheepskin pad: 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 section, under continuous passive motion (CPM).

Decision rationale: The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. The sheepskin would be used with the CPM, which had already been non-certified. Regarding Continuous Passive Motion (CPM) for the Shoulder, the ODG notes in the shoulder section: Not recommended for the shoulder. See the Knee Chapter for more information and Criteria for the use of continuous passive motion devices. (Raab, 1996) (BlueCross BlueShield, 2005) An AHRQ Comparative Effectiveness Review concluded that evidence on the comparative effectiveness and the harms of various operative and nonoperative treatments for rotator cuff tears is limited and inconclusive. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain, and one study found no difference in range of motion or strength. (Seida, 2010) The sheepskin pad would accompany the CPM device. This device was previously non-certified. As the CPM was non-certified, the sheepskin would likewise be unnecessary. The request is not medically necessary and appropriately non-certified.