

Case Number:	CM15-0054452		
Date Assigned:	03/27/2015	Date of Injury:	12/01/2009
Decision Date:	05/07/2015	UR Denial Date:	03/10/2015
Priority:	Standard	Application Received:	03/23/2015

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 61 year old female, who sustained an industrial injury on 12/01/2010. The injured worker is currently diagnosed as having status post right shoulder scope, cervical sprain/strain, and left shoulder sprain/strain and impingement syndrome with partial thickness rotator cuff tear. A left shoulder arthroscopy has been certified. Treatment to date has included chiropractic treatment, home exercise program, and medications. In a progress note dated 12/10/2014, the injured worker presented with complaints of decreased right shoulder pain with increased range of motion after physical therapy sessions. The treating physician reported discussing left shoulder scope with injured worker and wants to proceed pending response to right shoulder surgery. According to the application, Independent Medical Review is requested for associated surgical services related to left shoulder surgery.

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; initial period of forty-five (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, Shoulder Chapter, Continuous passive motion (CPM).

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: ODG guidelines indicate that continuous passive motion is not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis. The injured worker is having arthroscopy of the shoulder with subacromial decompression and possible rotator cuff debridement or repair. As such, the request for continuous passive motion rental for 45 days is not supported by guidelines and the medical necessity of the request has not been substantiated.

Surgi-Stim unit; initial period of ninety (90) days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular stimulation, Interferential electrical stimulation Page(s): 118, 121.

Decision rationale: The Surgi Stim device is a combination of neuromuscular and interferential electrical stimulation. California MTUS chronic pain guidelines indicate interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, and limited evidence of improvement on those recommended treatments alone. Randomized trials that have evaluated the effectiveness for shoulder pain resulted in either negative or non-interpretable findings. As such, the request for interferential electrical stimulation is not supported. With regard to neuromuscular electrical stimulation, the guidelines do not recommend NMES except as part of a rehabilitation program following a stroke. There is no evidence to support its use in chronic pain. As such, the request for a Surgi Stim device is not supported and the medical necessity of the request has not been established.

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, Shoulder Chapter, Continuous-flow cryotherapy.

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: ODG guidelines recommend continuous-flow cryotherapy as an option for 7 days after shoulder surgery. It reduces pain, swelling, inflammation, and reduces the need for narcotics after surgery. The general use is for 7 days. Usage beyond 7 days is not recommended. The request as stated is for coolcare cold therapy unit. The request does not indicate if it is a rental or purchase and if rental, the duration of the rental is not mentioned. As such, the medical necessity of the request cannot be determined.