

Case Number:	CM15-0068791		
Date Assigned:	04/21/2015	Date of Injury:	10/25/2013
Decision Date:	07/09/2015	UR Denial Date:	03/31/2015
Priority:	Standard	Application Received:	04/10/2015

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 is a 50 year old female, who sustained an industrial injury on October 25, 2013. The injured worker has been treated for right shoulder complaints. The diagnoses have included chronic right shoulder pain, right shoulder impingement syndrome, right subacromial joint cartilage disorder, right subacromial bursitis, right partial rotator cuff tear, adhesions right shoulder and subacromial spur. Treatment to date has included medications, radiological studies, cortisone injections and physical therapy. Current documentation dated March 23, 2015 notes that the injured worker reported right shoulder pain. Physical examination of the right shoulder revealed tenderness over the superolateral aspect and a positive impingement test, drop arm test and arc sign. The treating physician recommended right shoulder surgery which was planned for March 30, 2015. The treating physician's plan of care included a request for a continuous ice machine, abduction pillow brace, home exercise kit, transcutaneous electrical nerve stimulation unit and compression stockings.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative Continuous ice machine: 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 shoulder chapter, continuous-flow cryotherapy.

Decision rationale: This patient presents with chronic shoulder pain. The current request is for Post-operative Continuous ice machine. Treatment to date has included medications, radiological studies, cortisone injections, surgery and physical therapy. The Request for Authorization is dated 03/23/15. The patient is TTD. The MTUS and ACOEM guidelines do not discuss cold therapy units. Therefore, ODG Guidelines are referenced. ODG Guidelines under the shoulder chapter has the following regarding continuous-flow cryotherapy: "Recommended as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use." This patient is status post right shoulder surgery on 03/30/15. Progress report 03/17/15 and RFA dated 03/23/15 requested post-operative DME continuous ice machine. Duration of use was not specified. The MTUS Guideline recommends the duration of postoperative use to be up to 7 days. While guidelines support cold therapy as an appropriate post-op measure, without a clearer statement of the desired duration of therapy this device cannot be substantiated. The request IS NOT medically necessary.

Abduction pillow brace: Overturned

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: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official disability guidelines shoulder chapter, Abduction pillow brace.

Decision rationale: This patient presents with chronic shoulder pain. The current request is for Abduction pillow brace. Treatment to date has included medications, radiological studies, cortisone injections and physical therapy. The Request for Authorization is dated 03/23/15. The patient is TTD. ACOEM guidelines Shoulder chapter, Chapter: 9, page 204: Under Options, it allows for "Sling for acute pain," under rotator cuff tear and as a "sling for comfort," for AC joint strain or separation. Regarding Abduction pillow brace, the ODG under the shoulder chapter states "Recommended as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs." The patient has chronic right shoulder pain, right shoulder impingement syndrome, right subacromial joint cartilage disorder, right subacromial bursitis, right partial rotator cuff tear, adhesions right shoulder and subacromial spur. On 03/30/15 the patient underwent right shoulder surgery. The treater recommended an Abduction pillow for post-operative use. The ACOEM guidelines provide support for the use of abduction pillow brace for rotator cuff tears and ODG states recommended as an option following rotator cuff repair. The request IS medically necessary.

Home exercise kit: Overturned

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: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation Official disability guidelines Shoulder Chapter regarding Shoulder Kits.

Decision rationale: This patient presents with chronic shoulder pain. The current request is for Home exercise kit. Treatment to date has included medications, radiological studies, cortisone injections and physical therapy. The Request for Authorization is dated 03/23/15. The patient is TTD. ACOEM, Chapter 12, page 309 states, "There is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise." ODG Guidelines under the Shoulder Chapter regarding Shoulder Kits states "Recommended. See Exercises, where home exercise programs are recommended; & Physical therapy, where active self-directed home physical therapy is recommended. In this RCT a specific shoulder home exercise program resulted in 69% good outcomes versus 24% in the sham exercise group, and 20% of patients in the specific exercise group subsequently chose to undergo surgery versus 63% in the control group. (Holmgren, 2012)" On 03/30/15 the patient underwent right shoulder surgery. Given the strong support for exercise in general, and a specific recommendation for exercise kit found under shoulder chapter, the current request appears reasonable. The requested home exercise kit for the right shoulder IS medically necessary.

Tens unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tens.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS in chronic intractable pain Page(s): 114-116.

Decision rationale: This patient presents with chronic shoulder pain. The current request is for TENS unit. Treatment to date has included medications, radiological studies, cortisone injections and physical therapy. The Request for Authorization is dated 03/23/15. The patient is TTD. According to MTUS Chronic Pain Management Guidelines the criteria for use of TENS in chronic intractable pain (p116) "a one month trial period of the TENS unit should be documented (as an adjunct to other treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function during this trial." This patient is status post right shoulder surgery on 03/30/15. Progress report 03/17/15 and RFA dated 03/23/15 requested post-operative DME "TENS unit." MTUS requires documentation of one month trial prior to dispensing home units. The treater does not specify the duration the TENS unit is to be trialed. Furthermore, the patient does not meet the indications for a TENS unit. Therefore, the request IS NOT medically necessary.

Compression stockings: 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 shoulder chapter, Compression Garments.

Decision rationale: This patient presents with chronic shoulder pain. The current request is for Compression stockings. Treatment to date has included medications, radiological studies, cortisone injections and physical therapy. The Request for Authorization is dated 03/23/15. The patient is TTD. ODG shoulder chapter online for Compression Garments states: Not generally recommended in the shoulder. Deep venous thrombosis and pulmonary embolism events are common complications following lower-extremity orthopedic surgery, but they are rare following upper-extremity surgery, especially shoulder arthroscopy. This patient is status post right shoulder surgery on 03/30/15 and the treater has required compression stockings for post op use. The treater does not discuss the patient's risk of upper extremity DVT and why he cannot be treated with anticoagulation alone. Additionally, ODG guidelines do not support the use of compression garments such as stockings for the shoulder. Hence, the request for compression stockings IS NOT medically necessary.