MAXIMUS Federal Services

Case Number:	CM15-0082376		
Date Assigned:	05/04/2015	Date of Injury:	10/16/2009
Decision Date:	06/26/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	04/29/2015

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 68 year old male who sustained an industrial injury on 10/16/2009. Diagnoses include left shoulder impingement syndrome, supraspinatus tendinitis, acromioclavicular degenerative joint disease and bursitis. In addition he has diagnoses of lumbar spine sprain/strain with left lower extremity radiculitis, and left sacroiliac joint sprain, 4mm left disc protrusion at L5-S1, 4mm disc protrusion with mild central canal stenosis, facet degenerative joint disease at L4-L5, left knee sprain with patellofemoral arthralgia, left foot/first toe metatarsophalangeal sprain/strain, and status post left knee surgery on 02/03/2015. Treatment to date has included diagnostic studies, medications, subacromial injection, and physical therapy. A physician progress note dated 03/13/2015 documents the injured worker has left shoulder pain that he rates as 7-8 out of 10. He has pain in the low back, neck, left knee, left shoulder and foot. Left shoulder range of motion is restricted. There is left subacromial crepitus present. Acromioclavicular joint compression test is positive on the left, and Impingement I, II, and III are positive on the left. The treatment plan includes left shoulder surgery, post-operative physical therapy, and pre-operative clearance. The requested surgical procedure was certified by utilization review. Treatment requested is for associated surgical service: 1 continuous passive motion machine, Associated surgical service: 1 shoulder immobilizer with abduction pillow, post op 1 Surgi-Stim unit for 90 days, and post op purchase of 1 cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: 1 continuous passive motion 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), Shoulder (Acute and Chronic).

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 do not recommend postoperative continuous passive motion for shoulder rotator cuff problems or impingement syndrome but recommend it as an option for adhesive capsulitis. A review of the medical records does not indicate the presence of adhesive capsulitis. As such, the request for continuous passive motion unit is not supported and the medical necessity of the request has not been substantiated.

Post op 1 Surgi-Stim unit for 90 days: Upheld

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

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

Decision rationale: Surgi Stim is a trademark used for medical equipment and supplies, namely electronic nerve and muscle stimulator and interferential stimulator. The California MTUS chronic pain medical treatment guidelines do not recommend interferential current stimulation as an isolated intervention. Neuromuscular electrical stimulation is used primarily as part of a rehabilitation program following a stroke. As such, the request for a Surgi Stim unit for 90 days is not supported and the medical necessity of the request has not been substantiated.

Post op purchase of 1 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), Shoulder (Acute & Chronic).

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 following shoulder surgery for 7 days. It reduces pain, swelling, inflammation, and the need for narcotics after surgery. Use beyond 7 days is not recommended. The request as stated is for

purchase of a cold therapy unit which is not supported by guidelines. As such, the medical necessity of the request has not been substantiated.

Associated surgical service: 1 shoulder immobilizer with abduction pillow: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Postoperative abduction pillow sling.

Decision rationale: ODG guidelines recommend postoperative abduction pillow sling 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 are not recommended for arthroscopic repairs. As such, the request for a shoulder immobilizer with abduction pillow is not supported by guidelines and the medical necessity of the request has not been substantiated.