

Case Number:	CM15-0086753		
Date Assigned:	05/11/2015	Date of Injury:	09/12/2012
Decision Date:	06/30/2015	UR Denial Date:	04/10/2015
Priority:	Standard	Application Received:	05/05/2015

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: Illinois, California, Texas

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 53-year-old female who sustained an industrial injury on 9/12/12. Injury occurred while she was shooting for qualification at a shooting range. Past surgical history was positive for right shoulder arthroscopic subacromial decompression and acromioplasty, resection of the coracoacromial ligament, extensive subacromial and subdeltoid bursectomy, glenohumeral synovectomy, chondroplasty, debridement, distal clavicle resection, debridement of labrum and labral fraying, and debridement of a partial rotator cuff tear on 8/30/13. The 1/3/15 left shoulder MRI impression documented tendinosis and peritendinitis of the supraspinatus tendon with no rotator cuff tear. There was tenosynovitis of the long head of the biceps tendon, and arthropathy of the acromioclavicular joint. There was a lateral downsloping acromion resulting in lateral arch narrowing. The 3/2/15 treating physician report cited persistent left shoulder symptoms. Shoulder range of motion was documented as flexion 140, extension 40, abduction 140, adduction 40, external rotation 80, and internal rotation 0 degrees. There was severe tenderness over the supraspinatus, and moderate tenderness over the greater tuberosity, and biceps tendon. There was global 4/5 shoulder strength. Impingement tests were positive. Authorization was requested for left shoulder diagnostic arthroscopy, arthroscopic subacromial decompression, distal clavicle resection, exam and manipulation under anesthesia, and labral and/or cuff debridement and capsular release. Additional requests included left shoulder immobilizer with abduction pillow, continuous passive motion device, continuous cold therapy unit and a muscle stimulation unit. The 4/10/15 utilization review certified the request for left shoulder diagnostic arthroscopy, arthroscopic subacromial decompression, distal clavicle resection, exam and

manipulation under anesthesia, and labral and/or cuff debridement and capsular release. The request for 45-day rental of a continuous passive motion device was modified to 30 days consistent with guideline support for 4 weeks of use. The request for 90-day rental of a cold therapy unit was modified to 7 days consistent with guidelines. The request for a muscle stimulator unit for 90 days was non-certified as there was no guideline support. The request for a shoulder immobilizer with abduction pillow was modified to an immobilizer as the injured worker was undergoing arthroscopic surgery and there was no evidence of a massive rotator cuff tear.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Continuous passive motion device, 45 day rental: 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 2010.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Continuous passive motion (CPM).

Decision rationale: The California MTUS are silent regarding continuous passive motion (CPM) units. The Official Disability Guidelines do not recommend CPM units for rotator cuff problems. These units are recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. The 4/10/15 utilization review modified this request and certified a home continuous passive motion unit for 30 days consistent with guidelines. There is no compelling reason to support additional certification of a home CPM unit at this time. Therefore, this request is not medically necessary.

Associated surgical service: Cold therapy unit, 90 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 (ODG), Knee Chapter.

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

Decision rationale: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. The use of a cold therapy unit would be reasonable for 7 days post-operatively. The 4/10/15 utilization review modified this request and certified a 7-day rental of a cold therapy unit consistent with guidelines. There is no compelling reason to support additional certification of a cold therapy unit at this time. Therefore, this request is not medically necessary.

Associated surgical service: Muscle stimulation unit, 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 Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: The California MTUS guidelines recommend the use of transcutaneous electrotherapy in the treatment of pain when specific indications are met for individual electrotherapy modalities. In general, the guidelines do not recommend the use of any form of electrical stimulation as a primary treatment modality. There is no guideline support for the use of neuromuscular electrical stimulation for chronic pain or post-operative treatment. Galvanic stimulation is considered investigational for all indications. Interferential current stimulation is supported for a one-month trial if pain is ineffectively controlled by medications or the patient has been unresponsive to conservative measures. Guideline criteria have not been met. There is no indication that standard post-op pain management would be insufficient. There is no documentation that the patient was intolerant or unresponsive to pain medications during the pre-operative period. Therefore, this request is not medically necessary.

Associated surgical service: shoulder immobilizer with abduction pillow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling.

Decision rationale: The California MTUS are silent regarding post-op abduction pillow slings. The Official Disability Guidelines state that these slings are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. There is no evidence of a massive rotator cuff tear and arthroscopic surgery is planned. The 4/10/15 utilization review modified the request and certified a shoulder immobilizer. There is no compelling reason to support the medical necessity of an abduction pillow sling over a standard immobilizer. Therefore, this request is not medically necessary.