

Case Number:	CM14-0121408		
Date Assigned:	09/25/2014	Date of Injury:	09/10/2010
Decision Date:	10/27/2014	UR Denial Date:	07/11/2014
Priority:	Standard	Application Received:	07/31/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine, Spinal Cord Medicine and is licensed to practice in Massachusetts. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 claimant is a 50 year-old female without significant past medical history who sustained a work injury occurring on 09/13/10 while working as a caregiver when she injured her right shoulder and hand while moving a patient. She has not returned to work. She was seen on 10/21/13. She was having ongoing right shoulder pain, stiffness, tenderness, swelling, and weakness. A magnetic resonance image had showed findings of a partial thickness rotator cuff tear, superior labral tear, acromioclavicular degenerative joint disease, and a biceps tendon tear. The claimant's pain was rated at 9/10. The physical examination findings included decreased right shoulder range of motion with severe supraspinatus tenderness, moderate greater tuberosity tenderness, and mild biceps tendon tenderness. There was tenderness over the acromioclavicular joint and subacromial crepitus. There was decreased right upper extremity strength. Impingement testing was positive. Recommendations included arthroscopic surgery. She underwent this on 05/23/14 with a subacromial decompression, labral debridement, and distal clavicle resection. She was seen by the requesting provider on 07/03/14. She was having ongoing right shoulder pain and weakness. She had been unable to participate in postoperative physical therapy due to a family emergency and had only been able to attend three treatment sessions but was performing home exercises. The physical examination findings included decreased range of motion and strength with shoulder tenderness. She was continued at temporary total disability. Norco 10/325 mg #90 and Zanaflex 4 mg #30 were prescribed. On 07/30/14 she had increased shoulder range of motion. She was performing the home exercise program. The physical examination findings included decreased shoulder range of motion and strength. She was continued out of work. On 09/05/14 she had improved since surgery but there had been no change since the previous evaluation. She had not attended additional therapy treatment sessions. Physical examination

findings included shoulder atrophy with spasms and tenderness. She had decreased right upper extremity strength. She was referred for additional physical therapy. Norco 7.5 mg #90 was prescribed. Zanaflex was discontinued and Fexmid 7.5 mg #60 was prescribed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Date of service 5/23/14 Cryotherapy Unit (CTU) with Pad: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

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

Decision rationale: The claimant is four years status post work-related injury, undergoing a right shoulder arthroscopic subacromial decompression, labral debridement, and distal clavicle resection on 05/23/124. Her surgery appears to have been uncomplicated and with an expected post-op course. She has no pre-morbid past medical history or history of prior shoulder surgery that would place her at risk for a suboptimal outcome. Continuous-flow cryotherapy is recommended as an option after surgery. Postoperative use generally may be up to 7 days including home use. In this case, a 90 day rental of the unit was requested which was not medically necessary.

Retrospective Date of Service 5/23/14 Cold Therapy Wrap (Purchase) Shoulder: Overturned

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 (Acute & Chronic), Cold packs

Decision rationale: The claimant is four years status post work-related injury, undergoing a right shoulder arthroscopic subacromial decompression, labral debridement, and distal clavicle resection on 05/23/124. Her surgery appears to have been uncomplicated and with an expected post-op course. She has no pre-morbid past medical history or history of prior shoulder surgery that would place her at risk for a suboptimal outcome. The use of cold packs is recommended. Cold is believed to have therapeutic benefits including decreasing inflammation and swelling. Self-applications should be home-based. The guidelines recommend the use of low-tech cryotherapies. The requested cold therapy wrap was therefore medically necessary.

Retrospective Date of Service 5/23/14 rental Continuous Passive Motion Shoulder x 21 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

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

Decision rationale: The claimant is four years status post work-related injury, undergoing a right shoulder arthroscopic subacromial decompression, labral debridement, and distal clavicle resection on 05/23/124. Her surgery appears to have been uncomplicated and with an expected post-op course. She has no pre-morbid past medical history or history of prior shoulder surgery that would place her at risk for a suboptimal outcome. Continuous passive motion (CPM) is not recommended after shoulder surgery and the requested rental of a rental continuous passive motion shoulder unit for 21 days was not medically necessary.

Retrospective Date of Service 5/23/14 Shoulder Orthosis: 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 (Acute & Chronic), Immobilization

Decision rationale: The claimant is four years status post work-related injury, undergoing a right shoulder arthroscopic subacromial decompression, labral debridement, and distal clavicle resection on 05/23/124. Her surgery appears to have been uncomplicated and with an expected post-op course. She has no pre-morbid past medical history or history of prior shoulder surgery that would place her at risk for a suboptimal outcome. Immobilization is not recommended as a primary treatment. Early mobilization benefits include earlier return to work, decreased pain, swelling, and stiffness, and a greater preserved range of joint motion, with no increased complications. Immobilization is also a major risk factor for developing adhesive capsulitis. Therefore the requested shoulder orthosis was not medically necessary.

Interferential Stimulation digital Unit and supplies: 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 (Acute & Chronic), Interferential current stimulation (ICS)

Decision rationale: The claimant is four years status post work-related injury, undergoing a right shoulder arthroscopic subacromial decompression, labral debridement, and distal clavicle resection on 05/23/124. Her surgery appears to have been uncomplicated and with an expected

post-op course. She has no pre-morbid past medical history or history of prior shoulder surgery that would place her at risk for a suboptimal outcome. Interferential stimulation is not recommended as an isolated intervention and its use may be no more effective than exercise alone. In this case, the claimant was able to perform a home exercise program with benefit after participating in 3 sessions of physical therapy. Therefore the requested interferential stimulation digital unit and supplies was not medically necessary.