

Case Number:	CM14-0165006		
Date Assigned:	10/10/2014	Date of Injury:	03/08/2011
Decision Date:	12/15/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	10/07/2014

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 Orthopedic Surgery, and is licensed to practice in Arizona. 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:

This is a 54-year-old female with a date of injury of 3/8/2011. The patient had a slip and fall which resulted in an injury to her right shoulder. An MR scan of her shoulder dated 11/18/2011 revealed an insertional tear of the right shoulder rotator cuff. The patient has failed attempts at aggressive conservative management and continues to complain of pain with activity in the left shoulder. Examination reveals tenderness in the supraspinatus area and over the greater tuberosity. She has decreased strength with forward flexion, lateral abduction, and external rotation. There is tenderness over the acromioclavicular joint on compression. The patient has been approved for right shoulder arthroscopic surgery with rotator cuff repair, subacromial decompression, and distal clavicle resection. In addition to the surgery there are several requests for postoperative care. This includes physical therapy without any specific amount, electrical stimulation unit for 90 days, cold therapy for unspecified amount of time, and CPM for 45 days.

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 for an initial period of 45 days: 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, continuous passive motion.

Decision rationale: Continuous passive motion devices are not recommended by the ODG for shoulder rotator cuff problems either postoperatively or for nonsurgical treatment. Therefore, the medical necessity for a continuous passive motion device has not been established.

Postoperative Physical Therapy, unspecified: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: The postsurgical treatment guidelines do allow 40 visits of Physical Therapy over 16 weeks postoperatively for rotator cuff repair. However, the request submitted for this patient does not have an amount of visits and therefore is an open ended request that could continue indefinitely. The medical necessity for Physical Therapy with unspecified visits has not been established.

Electrical Stim Unit for an initial period of 90 days: 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, transcutaneous electrical nerve stimulation.

Decision rationale: The MTUS guidelines did not specifically address postop use of a TENS unit after shoulder surgery. The ODG states it is recommended post- stroke to improve passive humeral lateral motion. For other shoulder conditions, the use of a TENS unit is not supported by high-quality medical studies, but they may be useful in the initial conservative treatment of acute shoulder symptoms. Therefore, the medical necessity for postoperative use of a TENS unit has not been established.

Cold Therapy Unit, unspecified length of time: 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, continuous flow cryotherapy.

Decision rationale: Continuous flow cryotherapy is recommended after surgery for up to 7 days. The time is specific in the ODG. A request for cryotherapy which is unspecified in time can theoretically go on indefinitely. Therefore unless the amount of time is specified at 7 days, the medical necessity for cryotherapy has not been established.