

Case Number:	CM14-0173675		
Date Assigned:	10/24/2014	Date of Injury:	04/28/2014
Decision Date:	12/09/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/21/2014

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 Ohio, Tennessee, & Texas. 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 injured worker is a 63-year-old male who reported an injury on 04/28/2014 due to loading a luggage weighing more than 50 pounds he experienced left shoulder pain. Diagnoses were prominent glenohumeral effusion with evidence of osteochondral irregularity on a degenerative basis and moderate deformity of the glenohumeral articulation, osteophyte formation, acromioclavicular joint with grade 2 acromion, full thickness tear, 1.5 cm supraspinatus tendon. Arthroscopy left shoulder to include repair of rotator cuff and excision of distal clavicle. History of left shoulder x-ray that revealed slight degenerative changes of acromioclavicular joint, and right forearm strain, no symptoms at this time. Past treatments were medications, massage, physical therapy, heat pad, and exercise. Diagnostic studies were x-rays of the left shoulder, MRI of the left shoulder that revealed a tear, and an ultrasound of the left shoulder that revealed positive findings. The injured worker underwent left shoulder arthroscopic surgery 08/03/2013. He received 12 sessions of postoperative physical therapy. The injured worker continued to complain of left shoulder pain. A second left shoulder surgery was recommended and is pending authorization. The injured worker described the left shoulder pain as a 6/10, becoming a 7/10 with any prolonged motion at or above shoulder level. Examination of the left shoulder revealed a Neer's impingement sign, Hawkins sign, and apprehension sign were positive. There was a slight decrease in motor strength of the left shoulder. Active range of motion was decreased. Reflexes were 2+ for the biceps, triceps, and brachioradialis on the left. Sensation was intact to light touch and pinprick in the upper extremities. The injured worker received physical therapy twice a week from 01/2014 until 04/2014. He also had a TENS unit dispensed for home use. The treatment plan was for left shoulder surgery. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical services: home continuous passive motion (CPM) machine x 45 minutes: 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/Continuous Passive Motion (CPM)

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: The decision for associated surgical services: home continuous passive motion (CPM) machine x 45 minutes is not medically necessary. The Official Disability Guidelines state that continuous passive motion (CPM) is not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Continuous passive motion is not recommended for shoulder surgery or for nonsurgical treatment. The medical guidelines do not support the use of continuous passive motion for rotator cuff surgery. It is recommended for adhesive capsulitis. Therefore, this request is not medically necessary.

Associated surgical services: surgi-stim unit x 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 Shoulder/Neuromuscular electrical stimulation (NMES devices)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NMES, Interferential Current Stimulation, Galvanic Stimulation, Page(s): 121, 118, 117.

Decision rationale: The decision for associated surgical services: surgi-stim unit x 90 days is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines do not recommend neuromuscular electrical stimulation (NMES devices) as there is no evidence to support its use in chronic pain. They do not recommend interferential current stimulation (ICS) as an isolated intervention and galvanic stimulation is considered investigational for all indications. It is characterized by high voltage, pulse stimulation and is used primarily for local edema reduction through muscle pumping and polarity effect and is not recommended. The medical guidelines do not support the use of an orthostim unit. There were no other significant factors provided to justify the use outside of current guidelines. Therefore, this request is not medically necessary.

Associated surgical services: coldcare 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/Continuous-flow cryotherapy

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 decision for associated surgical services: cold care cold therapy unit is not medically necessary. The Official Disability Guidelines recommend it as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage, however, the effect on more frequently treated acute injuries such as muscle strains and contusions has been fully evaluated. Continuous flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. The request submitted for review does not indicate the frequency of usage and for how long. It also does not indicate if this is for purchase or for rental. Therefore, this request is not medically necessary.