

Case Number:	CM14-0179068		
Date Assigned:	11/03/2014	Date of Injury:	08/13/2012
Decision Date:	12/09/2014	UR Denial Date:	10/03/2014
Priority:	Standard	Application Received:	10/28/2014

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 Family Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in California. 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 patient is a 44-year-old male with a date of injury on August 13, 2012 to the right shoulder. Right shoulder MRI on November 1, 2012 revealed rotator cuff tear with tendinosis and fluid into subdeltoid space. Right shoulder x-ray on August 26, 2013 revealed early degenerative joint disease of the acromioclavicular joint. Treatment to date has consisted of physical therapy, medications, and injections which provided temporary relief. QME supplemental report dated May 27, 2014 indicated that the patient may be an appropriate surgical candidate. The patient was seen on September 15, 2014 at which time he complained of moderate right shoulder pain. Examination revealed atrophy of the supraspinatus muscle, tenderness, positive Neer's Hawkins, and Jobe's test. Examination also revealed 4/5 abduction and external rotation strength, tenderness at the acromioclavicular joint and positive anterior and posterior acromioclavicular joint stress tests. Surgical intervention was requested for symptomatic rotator cuff tear, impingement syndrome and distal clavicle arthrosis, right shoulder. Utilization review was performed on October 3, 2014 at which time the request for 30 day rental of a cold therapy units and 30 day rental of continuous passive motion machine was noncertified. It was noted that cold therapy unit may be indicated for up to seven days. It was also noted that continuous passive motion machine is not recommended for use for shoulder rotator cuff problems. The prior peer reviewer also noted that there is no indication that the request of surgery was deemed medically necessary at this time.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 day rental of a Cold Therapy Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Table 9-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chapter: 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: According to ODG, continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In this case, while the patient may be an appropriate surgical candidate, the request for 30 day units exceeds the number of days recommended by ODG for post op use of continuous flow cryotherapy units. Modification cannot be rendered in this review. Therefore, the request for 30 day rental of cold therapy unit is not medically necessary.

30 day rental of a Continuous Passive Motion Machine Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Table 9-6. 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) Continuous passive motion (CPM)

Decision rationale: According to ODG, 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. References state that for rotator cuff tears, CPM is not recommended after shoulder surgery or for nonsurgical treatment. In this case, the patient is recommended to undergo arthroscopic rotator cuff repair, acromioplasty and distal clavicle resection. The patient does not meet ODG's criteria for CPM unit. The request is not medically necessary.