MAXIMUS Federal Services

Case Number:	CM14-0092367		
Date Assigned:	08/06/2014	Date of Injury:	01/18/2011
Decision Date:	10/10/2014	UR Denial Date:	06/10/2014
Priority:	Standard	Application Received:	06/18/2014

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 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 47-year-old female with a reported date of injury on 01/18/2011. The mechanism of injury was due to a slip and fall. Her diagnoses were noted to include tears of the anterosuperior through anteroinferior labrum to the right shoulder, type 2 acromion with impingement syndrome to the bilateral shoulders, 2 mm of acromioclavicular joint space and 7 mm of glenohumeral joint space to the right shoulder, and 2 mm of acromioclavicular joint space and 6 mm of glenohumeral joint space to the left shoulder. Her previous treatments were noted to include physical therapy, injections, medications, and acupuncture. The progress note dated 02/04/2014 revealed complaints of constant pain to the bilateral shoulders rated 4/10 to the right shoulder and 5/10 to 6/10 to the left shoulder. The injured worker complained of numbness and tingling to the right shoulder and left arm and hand. She has a limited and painful range of motion to the left shoulder. The physical examination of the shoulder revealed tenderness to pressure bilaterally with positive Neer's and Hawkins. There was a positive drop arm/supraspinatus test. The active range of motion to the bilateral shoulders was noticed to be diminished. The motor strength was rated 4/5 with flexion and abduction bilaterally, as well as with external and internal rotation of the left shoulder. The progress note dated 03/04/2014 revealed complaints of pain and discomfort in the right shoulder described as aching in nature and pain and discomfort in the left shoulder described as burning, stabbing, and aching in nature. The injured worker rated her right shoulder pain level at 7/10 and left shoulder pain level at 8/10. The physical examination of the shoulder revealed tenderness to pressure to the acromioclavicular joint, and the middle and posterior portion of the shoulder joint. There were positive tests for impingement with Neer's and Hawkins bilaterally. There was a positive drop arm/supraspinatus test to the left shoulder. The test for instability rated positive on the anterior apprehension bilaterally. The range of motion to the bilateral shoulders was diminished. The

motor strength was graded 4/5 on flexion, extension, adduction, and internal and external rotation of the bilateral shoulders. The provider indicated he was requesting authorization for right shoulder arthroscopy with repair of the SLAP lesion and Mumford procedure. The progress note dated 05/13/2014 revealed complaints of pain and discomfort to the right shoulder that radiate to the right elbow and right wrist described as tingling and aching in nature, more with range of motion. The objective findings revealed a status post a superior labral tear from anterior to posterior lesion repair, Mumford procedure, and anterior subacromial decompression. The physical examination revealed right shoulder complaints with mobility and discomfort with reaching to the left shoulder. Impingement testing elicited right shoulder complaints. The Request for Authorization form was not submitted within the medical records. The request was for a Pro Sling II purchase for postoperative internal rotation contractures and to protect the surgical site; abduction pillow; shoulder CPM unit to facilitate range of motion and active physical therapy; Q-Teck cold therapy unit for up to 7 days to decrease pain, inflammation, swelling, and narcotic usage; and Pro Tech Multi stimulator unit for 14 days for reduction of pain, swelling, and inflammation and as an adjunctive therapy to facilitate range of motion and active physical therapy. The Request for Authorization form and the provider's rationale was not submitted for the abduction pillow, half arm wrap, universal therapy wrap, and electrodes and batteries.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pro sling II purchase.: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Post op pillow / sling.

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 request for Pro sling II purchase is medically necessary. The injured worker had a superior labral tear from anterior to posterior repair performed 04/2014. The Guidelines recommend a postoperative abduction pillow sling as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. The injured worker had a SLAP lesion and Mumford procedure done arthroscopically and the postoperative abduction sling is recommended for large and massive rotator cuff tears repaired open. The sling/pillow is a standard of care following labral tear surgery. Therefore, the request for Pro sling II purchase is medically necessary.

Abduction pillow: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Post op pillow / sling.

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 request for Abduction pillow is medically necessary. The injured worker had a superior labral tear from anterior to posterior repair performed 04/2014. The Guidelines recommend a postoperative abduction pillow sling as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. The injured worker had a SLAP lesion and Mumford procedure done arthroscopically and the postoperative abduction sling is recommended for large and massive rotator cuff tears repaired open. The sling/pillow is a standard of care following labral tear surgery. Therefore, the request for Abduction pillow is medically necessary.

Half Arm Wrap: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Post op pillow / sling.

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 request for Half Arm Wrap is not medically necessary. The injured worker had an arthroscopic SLAP lesion repair performed in 04/2014. The previous request for a Q-tek cold therapy rental unit was deemed not medically necessary and the associated supplies are not appropriate at this time. Therefore, the request for Half Arm Wrap is not medically necessary.

Universal Therapy Wrap: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Post op pillow / sling.

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 request for Universal Therapy Wrap is not medically necessary. The injured worker had an arthroscopic SLAP lesion repair performed in 04/2014. The previous request for a Q-tek cold therapy rental unit was deemed not medically necessary and the associated supplies are not appropriate at this time. Therefore, the request for Universal Therapy Wrap is not medically necessary.

Electrodes and Batteries.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

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 request for Electrodes and Batteries is not medically necessary. The injured worker had an arthroscopic SLAP lesion repair performed in 04/2014. The previous request for a Pro-tech Multi Stim unit was deemed not medically necessary and therefore, associated supplied are not appropriate at this time. As such, the request for Electrodes and Batteries is not medically necessary.

Q-Teck Cold therapy unit rental.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints.

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 request for Q-Teck Cold therapy unit rental is not medically necessary. The injured worker had an arthroscopic SLAP lesion repair performed in 04/2014. The Official Disability Guidelines recommend continuous flow cryotherapy 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 the more frequently treated acute injuries have not been fully evaluated. Continuous flow cryotherapy units provide regulated temperatures through use of power to circulate ice water through the cooling packs. The injured worker had surgery in 04/2014 and therefore a Q-Teck cold therapy unit is not recommended for nonsurgical treatment. Therefore, the request for Q-Teck Cold therapy unit rental is not medically necessary.

Shoulder CPM 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,Continuous Passive motion.

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

Decision rationale: The request for Shoulder CPM Unit is not medically necessary. The injured worker had a SLAP lesion repair in 04/2014. The Official Disability Guidelines do not recommend continuous passive motion for shoulder rotator cuff problems, but recommend it as an option for adhesive capsulitis, up to 4 weeks/5 days per week. The Guidelines do not recommend CPMs after shoulder surgery or for nonsurgical treatment. The injured worker does not have a diagnosis of adhesive capsulitis and the surgery was performed in 04/2014 and the CPM is not recommended for nonsurgical treatment. Therefore, the request for Shoulder CPM Unit is not medically necessary.

Pro Tech Multi stimulator unit.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Interferential unit, Neuromuscular Stimulator unit Page(s): 114, 116, 118, 122.

Decision rationale: The request for Pro Tech Multi simulator unit is not medically necessary. The injured worker had a previous SLAP shoulder surgery repair performed in 04/2014. The California Chronic Pain Medical Treatment Guidelines do not recommend TENS as a primary treatment modality, but a 1 month home based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence based functional restoration. The Guideline criteria for the use of TENS is documentation of pain of at least months' duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, a 1 month trial of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. Other ongoing pain treatment should also be documented during the trial period, including medication usage. The Guidelines do not recommend interferential current stimulation as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise, and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain, and post-operative knee pain. The Guidelines do not recommend neuromuscular electrical stimulation. NMES is used primarily as part of a program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. The Guidelines do not recommend an NMES unit, as it is used to

rehabilitate atrophied upper extremity muscles following a stroke. The Guidelines recommend a TENS or interferential unit to be used as a trial 30 day basis and the requested failed to provide whether the Pro Tech Multi stimulator was to be used as a trial or purchase. The Guidelines do not recommend the NMES portion of the Pro Tech Multi stimulator unit and therefore, it is not appropriate. As such, the request for Pro Tech Multi simulator unit is not medically necessary.