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| Case Number: | CM14-0137166 | | |
| Date Assigned: | 09/05/2014 | Date of Injury: | 02/21/2008 |
| Decision Date: | 06/22/2015 | UR Denial Date: | 08/08/2014 |
| Priority: | Standard | Application Received: | 08/25/2014 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: North Carolina

Certification(s)/Specialty: Family Practice

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 57 year old male, who sustained an industrial injury on 2/01/2008. Diagnoses include bilateral shoulder parascapular strain with tendinitis, bursitis and impingement; right shoulder acromioclavicular degenerative joint disease status post right shoulder arthroscopy (3/24/2010), full thickness tear of the supraspinatus tendon (via 8/22/2013 arthrogram), biceps tenosynovitis versus tear, labral changes and acromioclavicular joint degenerative changes. Treatment to date has included diagnostics, surgical intervention, medications including Voltaren gel and Norco and home exercise. Per the Primary Treating Physician's Progress Report dated 7/10/2014, the injured worker reported left shoulder pain with popping and clicking. Physical examination revealed tenderness to palpation over the subacromial region, acromioclavicular joint and supraspinatus tendon. Crepitus was present. There was decreased range of motion of the left shoulder. The plan of care included surgical intervention and a left shoulder arthroscopy has been authorized. Authorization was requested for one preoperative medical clearance, 12 postoperative supervised rehabilitative therapy sessions, one continuous passive motion (CPM) device for home use for 45 days, one surgi-stim unit for 90 day rental and one cold care cold therapy unit for 90 day use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continuous passive motion device for home use: 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 (CPM).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, continuous passive motion.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. Per the Official Disability Guidelines section on CPM, it may offer beneficial results compared to PT alone in the short-term rehabilitation following total knee arthroplasty. Criteria for the use of CPM devices included: May be considered medically necessary for up to 21 days postoperatively for the following surgical procedures: 1. Total knee arthroplasty. 2. Anterior cruciate ligament reconstruction. 3. Open reduction and internal fixation of the tibial plateau or distal femur fractures involving the knee joint. The ODG does not indicate this is necessary post shoulder surgery for rotator cuff tears. Therefore, the request is not medically necessary.

Surgi-Stim unit for a 90 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Neuromuscular electrical stimulation (NMES).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines neuromuscular stimulation Page(s): 121.

Decision rationale: The California MTUS section on neuromuscular stimulation states: not recommended. NMES is used primarily as part of a rehabilitation 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. (Moore, 1997) (Gaines, 2004) The scientific evidence related to electromyography (EMG)-triggered electrical stimulation therapy continues to evolve, and this therapy appears to be useful in a supervised physical therapy setting to rehabilitate atrophied upper extremity muscles following stroke and as part of a comprehensive PT program. Neuromuscular Electrical Stimulation Devices (NMES), NMES, through multiple channels, attempts to stimulate motor nerves and alternately causes contraction and relaxation of muscles, unlike a TENS device which is intended to alter the perception of pain. NMES devices are used to prevent or retard disuse atrophy, relax muscle spasm, increase blood circulation, maintain or increase range-of-motion, and re-educate muscles. Functional neuromuscular stimulation (also called electrical neuromuscular stimulation and EMG-triggered neuromuscular stimulation) attempts to replace stimuli from destroyed nerve pathways with computer-controlled sequential electrical stimulation of muscles to enable spinal cord- injured or stroke patients to function independently, or at least maintain healthy muscle tone and strength. Also used to stimulate quadriceps muscles following major knee surgeries to maintain and enhance strength during rehabilitation. (BlueCross BlueShield, 2005) (Aetna, 2005) The requested service includes

neuromuscular stimulation and therefore based on the above recommendations is not medically necessary.

Coolcare cold therapy unit for 90 day use: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, cryotherapy.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. The ACOEM does recommend the at home local application of cold packs the first few days after injury and thereafter the application of heat packs. The Official Disability Guidelines section on cryotherapy states: recommended as an option after surgery but not for nonsurgical treatment. The request is for post surgical use, but the ODG places a finite period of time this is recommended for use after surgery. The request is in excess of this period for and therefore not medically necessary.