MAXIMUS Federal Services

Case Number:	CM14-0155500		
Date Assigned:	09/25/2014	Date of Injury:	11/30/2009
Decision Date:	02/25/2015	UR Denial Date:	09/11/2014
Priority:	Standard	Application Received:	09/23/2014

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: California
Certification(s)/Specialty: Internal Medicine

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 an injured worker with a history of left shoulder injury and cervical strain. Date of injury was November 30, 2009. The operative report dated 09/02/2014 documented the performance of arthroscopic rotator cuff repair, superior labrum anterior posterior repair, arthroscopic subacromial decompression, distal clavicle undersurface resection, complete synovectomy, and extensive debridement. Diagnoses were left shoulder rotator cuff tear, superior labrum anterior posterior lesion, impingement, acromioclavicular joint arthritis, glenohumeral synovitis, and glenoid and humeral chondromalacia. The primary treating physician's progress report dated 12/16/14 documented subjective complaints of shoulder pain and back issues. The patient is receiving physical therapy. Physical examination was documented. Left shoulder forward flexion was ninety degrees. Low back tenderness was noted. Neurovascular was intact. Diagnoses were left shoulder labral tear, cervical strain, and low back pain. Treatment plan recommended physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 day post- operative rental thermacure and purchase1 thermacure pad to left shoulder:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203, 212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) Thermotherapy Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic) Durable medical equipment (DME).

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses heat therapy. American College of Occupational and Environmental Medicine (ACOEM) Chapter 9 Shoulder Complaints states that physical modalities, such as massage, diathermy, cutaneous laser treatment, ultrasound treatment, transcutaneous electrical neurostimulation (TENS) units, and biofeedback are not supported by high-quality medical studies. Table 9-6 Summary of Recommendations for Evaluating and Managing Shoulder Complaints indicates that passive modalities are not recommended. Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) states that thermotherapy are under study. For several physical therapy interventions and indications (eg, thermotherapy using heat, therapeutic exercise, massage, electrical stimulation, mechanical traction), there was a lack of evidence regarding efficacy. Official Disability Guidelines (ODG) state that durable medical equipment (DME) is defined as equipment which is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of injury.The operative report dated 09/02/2014 documented the performance of arthroscopic rotator cuff repair, superior labrum anterior posterior repair, arthroscopic subacromial decompression, distal clavicle undersurface resection, complete synovectomy, and extensive debridement. Diagnoses were left shoulder rotator cuff tear, superior labrum anterior posterior lesion, impingement, acromioclavicular joint arthritis, glenohumeral synovitis, and glenoid and humeral chondromalacia. ACOEM guidelines indicate that passive modalities are not recommended. Official Disability Guidelines (ODG) indicates that thermotherapy using heat lack of evidence regarding efficacy. The request for a Thermacure pad is not supported by MTUS, ACOEM, or ODG guidelines.Therefore, the request for 30 day post-operative rental thermacure and purchase1 thermacure pad to left shoulderis not medically necessary.