

Case Number:	CM15-0116009		
Date Assigned:	06/24/2015	Date of Injury:	01/14/2014
Decision Date:	08/21/2015	UR Denial Date:	06/01/2015
Priority:	Standard	Application Received:	06/16/2015

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: New York, Tennessee
 Certification(s)/Specialty: Emergency 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:

This 53 year old female sustained an industrial injury to bilateral shoulders on 1/14/14. Previous treatment included magnetic resonance imaging, chiropractic therapy, injections and medications. Right shoulder ultrasound (1/20/15) showed a rotator cuff tear with impingement syndrome. In a request for authorization dated 4/27/15, physical exam was remarkable for bilateral shoulder with limited range of motion, right shoulder with tenderness to palpation to the supraspinatus, greater tuberosity, biceps tendon and acromial joint, positive subacromial crepitus, 4/5 right upper extremity strength and positive acromial joint compression and impingement tests. Current diagnoses included right rotator cuff tear and status post motor vehicle accident. The treatment plan included right shoulder arthroscopy with decompression and rotator cuff repair with associated surgical services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shoulder Immobilizer with Abduction Pillow: 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 - Post operative abduction 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 Shoulder, Immobilization.

Decision rationale: Immobilization is not recommended as a primary treatment. Immobilization and rest appear to be overused as treatment. Early mobilization benefits include earlier return to work; decreased pain, swelling, and stiffness; and a greater preserved range of joint motion, with no increased complications. With the shoulder, immobilization is also a major risk factor for developing adhesive capsulitis, also termed "frozen shoulder". Immobilizer is not recommended. Postoperative abduction pillow sling is recommended as an option following open repair of large and massive rotator cuff tears and other shoulder surgeries. 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. A post-op sling is generally recommended for 2-4 weeks after any shoulder surgery. A good protocol is to begin weaning off the sling at two weeks, reducing the number of hours per day it is worn. In this case, the patient is undergoing arthroscopic surgery. Abduction pillow is not recommended. The request should not be authorized and therefore is not medically necessary.

Surgi-Stim Unit, 90 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS); Neuromuscular electrical stimulation (NMES devices).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 114-116, 118-119, 121.

Decision rationale: Surgi-Stim unit is a multi-stim unit. Multi-stim unit is a device that provides TENS, interferential, and neuromuscular stimulation. TENS units are not recommended as a primary treatment modality, but a one-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, including reductions in medication use, for neuropathic pain, phantom limb pain, spasticity, and multiple sclerosis. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. TENS units are recommended as a treatment option for acute post-operative pain in the first 30 days post-surgery. In this case, the requested duration of treatment surpasses the 30 days recommended. TENS therapy is not recommended. Interferential current stimulation (ICS) is not recommended 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. ICS is indicated when pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, there is a history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment, or the pain is unresponsive to conservative measures. This request is for postoperative therapy. ICS is not indicated.

Neuromuscular electrical stimulation (NMES) is 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. The request should not be authorized and therefore is not medically necessary.

Coolcare 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: 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: Coolcare Cold Therapy unit supplies continuous-flow cryotherapy. 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 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 (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy (i.e, frostbite) are extremely rare but can be devastating. In this case, cryotherapy is recommended for only 7 days. Cold therapy rental is recommended. Purchase of a unit is not medically indicated. The request should not be authorized and therefore is not medically necessary.

Continuous passive motion device, Home, 45 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: 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 motion device.

Decision rationale: Continuous motion devices are not recommended after shoulder surgery or for nonsurgical treatment. Evidence on the comparative effectiveness and the harms of various operative and non-operative treatments for rotator cuff tears is limited and inconclusive. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain, and one study found no difference in range of motion or strength. The request should not be authorized and therefore is not medically necessary.