

Case Number:	CM15-0176868		
Date Assigned:	09/17/2015	Date of Injury:	08/06/2012
Decision Date:	11/18/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	09/08/2015

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: California
 Certification(s)/Specialty: Orthopedic Surgery

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 64 year old female sustained an industrial injury on 8-6-12. Documentation indicated that the injured worker was receiving treatment for bilateral shoulder sprain and strain, right rotator cuff tear, lumbar spine sprain and strain, lumbar facet osteoarthritis and left knee pain. Previous treatment included left knee arthroscopy (12-17-14), physical therapy, aqua therapy, injections and medications. In a comprehensive orthopedic consultation dated 7-20-15, the injured worker complained of right shoulder pain, rated 7 out of 10 on the visual analog scale. Physical exam was remarkable for right shoulder with "severe" supraspinatus tenderness to palpation, "moderate" tenderness to palpation to the greater tuberosity and acromial joint and "mild" tenderness to palpation to the biceps tendon, range of motion: forward flexion 155 degrees, extension 90 degrees, abduction 155 degrees, adduction 40 degrees, external rotation 90 degrees and internal rotation 60 degrees, positive subacromial crepitus, 4 out of 5 strength and positive acromial joint compression and impingement tests. Magnetic resonance imaging right shoulder (6-17-15) showed tendinosis and peritendinitis of the supraspinatus tendon with a partial- thickness undersurface anterior supraspinatus tendon tear, tenosynovitis of the long head biceps tendon, arthropathy of the acromioclavicular joint and glenohumeral joint. The treatment plan included right shoulder decompression, distal clavicle resection, rotator cuff debridement and repair with associated surgical services. On 8-31-15, Utilization Review noncertified a request for a home CPM (initial period of 45 days) and modified a request for a Surgi-stim unit (initial period of 90 days) to a 30 day rental of a transcutaneous electrical nerve stimulator unit and a Cool care cold therapy unit to a cold therapy unit for 7 day rental. Utilization Review non-certified a request for DVT prophylaxis with pneumatic compression device and the necessary appliances.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical services: Home CPM (initial period of 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, CPM (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, CPM.

Decision rationale: CA MTUS/ACOEM guidelines are silent on the issue of CPM machine. According to the Official Disability Guidelines, Shoulder Chapter, Continuous passive motion (CPM), CPM is recommended for patients with adhesive capsulitis but not with patients with rotator cuff pathology primarily. With regards to adhesive capsulitis it is recommended for 4 weeks. As there is no evidence preoperatively of adhesive capsulitis in the exam note of 7/20/15, the determination is for not medically necessary.

Associated surgical services: Surgi-stim unit (initial period of 90 days): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: Regarding the Interferential Current Stimulation (ICS), the California MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation, pages 118-119 state, "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. 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 findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues." As there is insufficient medical evidence regarding use from the exam note of 7/20/15, the determination is for not medically necessary.

Associated surgical services: 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 Chapter, 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: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case the request exceeds the guidelines recommendation of 7 days. Therefore the determination is for not medically necessary.

Associated surgical services: DVT prophylaxis involving pneumatic compression device and the necessary appliances: 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 Chapter, Venous Thrombosis Section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee and Leg, Venous thrombosis.

Decision rationale: CA MTUS/ACOEM is silent on the issue of venous duplex. According to the ODG, knee and leg section, venous thrombosis, "Recommend identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures such as consideration for anticoagulation therapy." In this case the exam notes from 7/20/15 do not justify a prior history or current risk of deep vein thrombosis to justify venous thromboembolic prophylaxis following shoulder arthroscopy. Therefore the determination is for not medically necessary.