

Case Number:	CM15-0063947		
Date Assigned:	04/09/2015	Date of Injury:	04/07/2011
Decision Date:	06/08/2015	UR Denial Date:	03/20/2015
Priority:	Standard	Application Received:	04/03/2015

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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 32-year-old male, who sustained an industrial injury on April 7, 2011. The diagnoses have included right partial-thickness rotator cuff tear, right shoulder superior labral tear, right shoulder subacromial impingement and left shoulder pain secondary to subacromial impingement, possibly over compensatory in nature. Treatment to date has included medications, radiological studies, electrodiagnostic studies, injections, physical therapy, peripheral nerve block and right shoulder surgery. Current documentation dated November 25, 2014 notes that the injured worker reported ongoing left shoulder pain. Physical examination was noted to be unchanged from the prior visit. The injured worker was noted to have a painful arc of motion and a positive Neer and Hawkin's test. The treating physician's plan of care included a request for a sling for the left shoulder, cold therapy unit rental, compression therapy pad purchase and a transcutaneous electrical nerve stimulation unit purchase with two electrode packs.

IMR ISSUES, DECISIONS AND RATIONALES

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

Sling for the Left Shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205.

Decision rationale: California MTUS/ACOEM Practice Guidelines state patients with shoulder disorders tend to have stiffness followed by weakness and atrophy. Careful advice regarding maximizing activities within the limits of symptoms is imperative once red flags have been ruled out. If indicated, the joint can be kept at rest in a sling. Gentle exercise even during this time is desirable. In this case, the medical rationale for the requested durable medical equipment was not provided. There is no documentation of any red flags for serious pathology upon examination. There is no indication that this injured worker is currently a surgical candidate. As the medical necessity has not been established, the request is not medically appropriate at this time.

Cold Therapy Unit (14-day rental): Upheld

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

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

Decision rationale: 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. In this case, there is no indication that this injured worker is status post left shoulder surgery. The medical necessity for a cold therapy unit rental has not been established. A 14-day rental would also exceed guideline recommendations. Given the above, the request is not medically necessary.

Compression Therapy Pad (purchase): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Tens Unit (purchase with two electrodes packs): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Transcutaneous electrotherapy Page(s): 114-117.

Decision rationale: California MTUS Guidelines do not recommended transcutaneous electrotherapy as a primary treatment modality, but a 1-month home based trial may be considered as a noninvasive conservative option. There should be evidence that other appropriate pain modalities have been tried and failed including medication. In this case, there is no documentation of a successful 1-month trial prior to the request for a unit purchase. There is also no mention of an exhaustion of all conservative treatment prior to the request for a TENS unit. Given the above, the request is not medically necessary.