

Case Number:	CM15-0076200		
Date Assigned:	04/27/2015	Date of Injury:	05/31/2012
Decision Date:	06/29/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	04/21/2015

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: Illinois, California, Texas
 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:

The injured worker is a 51-year-old female who sustained an industrial injury on 5/31/12, relative to a continuous trauma. The 6/26/14 left shoulder ultrasound study revealed a partial thickness rotator cuff tear, acromioclavicular (AC) degenerative joint disease, and subacromial impingement. The contralateral right shoulder findings were similar. The 3/9/15 orthopedic report cited grade 8/10 left shoulder pain. Physical exam documented symmetrical shoulder range of motion with 145 degrees flexion and abduction, and internal rotation 45 degrees, and subacromial crepitus. There was severe tenderness over the supraspinatus tendon, moderate tenderness over the greater tuberosity and AC joint, and mild tenderness over the biceps tendon bilaterally. There was 5/5 shoulder strength bilaterally. Impingement tests were positive bilaterally, and AC joint compression test was positive on the left. The diagnosis was status post continuous trauma bilateral shoulder impingement syndromes. The treatment plan recommended left shoulder subacromial decompression, distal clavicle resection, and possible rotator cuff debridement versus repair. Additional requests were noted for home continuous passive motion (CPM) device, shoulder immobilizer with abduction pillow, Surgi-Stim unit, and Coolcare cold therapy unit. The request for left shoulder surgery was certified. The 4/16/15 utilization review non-certified the request for home CPM device as there was no evidence of adhesive capsulitis to support the medical necessity of use consistent with guidelines. The request for a shoulder immobilizer with abduction pillow was modified to a standard sling as there was no evidence of a large or massive rotator cuff tear or need for open surgery to support the medical necessity consistent with guidelines. The request for a Surgi-Stim unit was non-certified as there was no

evidence that significant pain would impede the injured worker's ability to participate in physical therapy and all components of the unit were not guideline supported. The request for Coolcare cold therapy unit was modified to 7-day rental of a cold therapy unit consistent with guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Home continuous passive motion (CPM) device: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, 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 passive motion (CPM).

Decision rationale: The California MTUS are silent regarding continuous passive motion (CPM) units. The Official Disability Guidelines do not recommend CPM units for rotator cuff problems. These units are recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Guideline criteria have not been met. Arthroscopic rotator cuff repair was planned. There is no clinical evidence suggestive of adhesive capsulitis. There is no compelling reason to support the medical necessity of this unit in the absence of guideline support. Therefore, this request is not medically necessary.

Associated surgical service: Shoulder immobilizer with abduction pillow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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.

Decision rationale: The California MTUS is silent regarding post-op abduction pillow slings. The Official Disability Guidelines state that post-op abduction pillow slings are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. This patient has a partial rotator cuff tear and arthroscopic repair is planned. Guidelines generally support a standard sling for post-operative use. There is no compelling reason to support the medical necessity of a specialized abduction sling over a standard sling as previously certified. Therefore, this request is not medically necessary.

Associated surgical service: Surgi-Stim unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: The SurgiStim unit provides a combination of interferential current, neuromuscular electrical stimulation (NMES), and galvanic current. The California MTUS guidelines for transcutaneous electrotherapy do not recommend the use of NMES in the treatment of chronic pain. Galvanic stimulation is considered investigational for all indications. Guidelines suggest that interferential current is not recommended as an isolated intervention. Patient selection criteria is provided if interferential stimulation is to be used despite lack of guideline support and includes ineffective pain control due to diminished effectiveness of medications, intolerance of medications, history of substance abuse, post-operative pain limiting functional ability, and failure to respond to conservative measures. Guideline criteria have not been met. There is no indication that standard post-op pain management would be insufficient. There is no documentation that the patient was intolerant or unresponsive to pain medications during the pre-operative period. If one or more of the individual modalities provided by this multi-modality unit is not supported, then the unit as a whole is not supported. Therefore, this request is not medically necessary.

Associated surgical service: 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 ODG, 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: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. The 4/16/15 utilization review decision recommended partial certification of a cold therapy unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.