

Case Number:	CM15-0093552		
Date Assigned:	05/19/2015	Date of Injury:	05/29/2011
Decision Date:	06/19/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/14/2015

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:

The injured worker is a 51 year old male, who sustained an industrial injury on 5/29/2011. The mechanism of injury is unknown. The injured worker was diagnosed as having right subacromial impingement syndrome. Ultrasound of the right shoulder showed right shoulder impingement with rotator cuff tendinitis and biceps tenosynovitis, Treatment to date has included 30 physical therapy visits, 2 steroid injections, 6 acupuncture treatments and medication management. In a progress note dated 3/25/2015, the injured worker complains of right shoulder pain with a pending right shoulder surgery. The treating physician is requesting Surgi-stim unit for an initial period of 90 days, then purchase, Cool-care cold therapy unit and home continuous passive motion device for 45 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associate Surgical Service: Surgi-stim unit for an initial period of 90 days, then purchase:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Transcutaneous electrical nerve stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Galvanic Stimulation Page(s): 117.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines, Galvanic Stimulation, page 117 and Interferential Current Stimulation, page 118, provide the following discussion regarding the forms of electrical stimulation contained in the SurgStim 4: Galvanic stimulation is not recommended by the guidelines for any indication. In addition, interferential current stimulation is not recommended as an isolated intervention. Therefore, the SurgStim 4 is not recommended by the applicable guidelines and is therefore 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 Official Disability Guidelines, Cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder Chapter, 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 is for an unspecified amount of days. Therefore, the determination is for non-certification. The request is not medically necessary.

Associated Surgical Service: Home continuous passive motion (CPM) device for an 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 (ODG), Shoulder Chapter, 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, Shoulder Chapter, Continuous passive motion (CPM).

Decision rationale: 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 3/25/15, the determination is for non-certification. The request is not medically necessary.