

Case Number:	CM14-0144893		
Date Assigned:	09/12/2014	Date of Injury:	09/28/2012
Decision Date:	10/06/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/08/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 63-year-old male sustained an industrial injury on 9/28/12. The mechanism of injury was not documented. The 2/27/13 left shoulder MRI findings were consistent with subacromial subdeltoid bursitis. There was tendinosis of the distal rotator cuff without evidence of a tear and mild to moderate glenohumeral and acromioclavicular joint osteoarthritis. A degenerative subchondral cyst was noted in the humeral head. The 6/27/14 treating physician report indicated the patient had failed extensive conservative treatment. Left shoulder range of motion was limited to 150 degrees of flexion and 145 degrees of abduction with crepitus documented. There was tenderness over the supraspinatus, greater tuberosity, biceps tendon, and acromioclavicular joint. Left shoulder strength was 4/5 globally. Acromioclavicular joint compression and impingement testing was positive. Surgery was recommended. The 8/19/14 utilization review certified the request for left shoulder arthroscopic subacromial decompression, distal clavicle resection, and labral and/or cuff debridement. The request for continuous passive motion was denied as not recommended for shoulder rotator cuff problems. The request for 90-day rental of a Surgi-Stim device was modified to a TENS unit for 30 days post-op use. The request for a XXXXXXXXXX cold therapy unit was modified to a 7-day rental of a cryotherapy unit. The request for abduction pillow was denied as the patient did not have a complete rotator cuff rupture consistent with guideline indications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Continuous Passive Motion (CPM) Device for 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 (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. Guideline criteria have not been met. Clinical exam does not support the diagnosis of adhesive capsulitis. There is no compelling reason for CPM in the absence of guideline support. Therefore, this request is not medically necessary.

Abduction Pillow- Large: 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, 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, Post-operative abduction pillow sling

Decision rationale: The California MTUS is silent regarding post-op abduction pillows. The Official Disability Guidelines recommend abduction pillow slings as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. There is no documentation that this patient had a massive rotator cuff tear or that an open repair is anticipated. Therefore, this request is not medically necessary.

Surgi-Stim Unit for Initial Period of Ninety Days: Upheld

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

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

Decision rationale: Under consideration is a request for post-operative Surgi-Stim rental. The Surgi-Stim 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 for post-operative rehabilitation. Galvanic stimulation is considered investigational for all uses. Guidelines support the use of post-op interferential current if significant pain limits the ability to perform exercise or physical therapy

treatment. Guideline criteria have not been met. There is no indication that post-operative pain management will be insufficient to allow this patient to perform exercise or physical therapy treatment. 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. Guidelines clearly do not support the use of galvanic stimulation. Therefore, this request is not medically necessary.

██████████ **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 (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 surgery for 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. This request for an unknown length of use is not consistent with guidelines. The 8/19/14 utilization review modified this request to allow for 7-day rental. There is no compelling reason to support the medical necessity of a cold therapy unit beyond guideline recommendation and the 7-day rental already certified. Therefore, this request is not medically necessary.