

<b>Case Number:</b>	CM13-0015760		
<b>Date Assigned:</b>	03/19/2014	<b>Date of Injury:</b>	08/22/2005
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	08/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2013

### 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 Texas. 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:

The injured worker is a 41 year old female who sustained an injury to her right shoulder from 10/20/99 through 08/22/05 due to cumulative trauma while performing her usual and customary duties as a custodian. Magnetic resonance image of the right shoulder dated 08/29/12 revealed subacromial impingement syndrome, tenosynovitis of the biceps tendon, and acromioclavicular degenerative joint disease. Physical examination of the right shoulder noted flexion 90 degrees, extension 40 degrees, abduction 90 degrees, adduction 40 degrees, external rotation 80 degrees, and internal rotation 40 degrees; forward flexion 4/5 strength, abduction 4/5 strength external/internal rotation strength 4/5; positive acromioclavicular joint compression; impingement I, II and III tests. The injured worker was approved for right shoulder surgical intervention.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CPM FOR 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 Procedure Summary.

**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 passive motion (CPM).

**Decision rationale:** The previous request was denied on the basis that there was limited evidence that the injured worker has adhesive capsulitis that would warrant the requested CPM machine. Absent such, medical necessity for the proposed intervention was not evident. The Official Disability Guidelines state that treatment with continuous passive motion is not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to four weeks/five days per week. Given that there were no signs/symptoms of adhesive capsulitis and the request exceeds the Official Disability Guidelines recommendations, the request for CPM machine is not medically necessary and appropriate.

**SURGI-STIM UNIT FOR 90 DAYS WITH POSSIBLE PURCHASE AFTER 90 DAY PERIOD:** 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) Pain Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, (transcutaneous electrical nerve stimulation) Page(s): 114-116.

**Decision rationale:** Furthermore, the use of galvanic stimulation and Neuromuscular Electrical Stimulation is not supported by evidence based guidelines. California Medical Treatment Utilization Schedule states that while transcutaneous electrical nerve stimulation (TENS) may reflect the longstanding accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long term effectiveness. Several published evidence based assessments of TENS have found that evidence is lacking concerning effectiveness. The request for surgi-stim unit for 90 days with possible purchase after 90 day period is not medically necessary and appropriate.

**COOLCARE COLD THERAPY UNIT:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines (ODG) Shoulder Procedure Summary.

**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:** Post-operative use generally may be up to seven days, including home use. Given that the injured worker was approved for right shoulder surgery, cold therapy unit is

indicated to address post-operative swelling and pain for seven day rental. The request for coolcare cold therapy unit is medically necessary.