

<b>Case Number:</b>	CM13-0026192		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	09/23/2009
<b>Decision Date:</b>	02/03/2014	<b>UR Denial Date:</b>	08/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Emergency Medicine 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 physician 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:

Patient with date of injury of 9/23/09. Patient felt pain in shoulder and a pop in his knee during work as a loader/unloader. Has a diagnosis of bilateral knee degenerative joint disease(DJD) s/p partial R knee replacement, patelloplasty and excision of Baker's cyst on 6/2012, L shoulder subacromial impingement syndrome, L acromioclavicular joint DJD, L shoulder glenoid labral tears, cervical and trapezius pain with bilateral upper extremity radiculopathy, multilevel thoracolumbar radiculopathy, disc protrusions and neuroforaminal stenosis and bilateral elbow pathology. Pt complains of L shoulder pains, stiffness, swelling and weakness. Report of pain is rated 8/10. Objective exam shows severe supraspinatous tenderness, moderate greater tuberosity tenderness, acromioclavicular(AC) joint tenderness, subacrominal crepitations with 4/5 strength in shoulder. Positive AC joint compression and impingement tests. Limited range of motion in all directions. Supplemental report by [REDACTED] (Orthopedics) on 12/12/13 in response to utilization review on 8/29/13 . Reports that patient underwent arthroscopic subacromial decompression, distal clavicle resection, debridement of the glenoid labral tears and partial thickness rotator cuff tear on 10/23/13. Last seen on 12/10/13 and pt reported sessions of post-operative care with increased ROM but persistent weakness and continued tenderness with limited ROM. MRI of L shoulder on 2/20/12 shows degenerative changes of the gleonohumeral joint with posterior labral tear and non-displaced superior tear. Supraspinatous tendonopathy and subscapularis. Mildly increased fluid. No rotator cuff tears. Reportedly completed physical therapy, steroid injections and oral anti-inflammatory with no improvement. Patient is noted to be on hydromorphone and Hydrocodone. Review request for rental of continuous passive movement(CPM) unit, rental for surgi-stim unit and rental of cool-care cold therapy unit. Utilization review on 8/29/13 certified surger

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Continuous passive movement (CPM) unit for a forty five (45) day rental:** 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).

**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) Section).

**Decision rationale:** The Official Disability Guidelines (ODG) recommends CPM for adhesive capsulitis but does not recommend CPM for rotator cuff problems. Evidence of CPM for rotator cuff problems is limited. The medical records yielded minimal improvement to no improvement. In the supplemental report of 12/12/13, the physician argues that as per ACOEM guidelines that primary clinician should have leeway in to determine appropriate medical therapy. However the physician did not provide any evidence or any other official guidelines to support his assertions. As per utilization review guidelines, this review is evidence-based and I'm not able to reverse prior non-certification for CPM based on the physician's professional opinion alone without evidence based studies or guidelines. CPM is not recommended.

**Surgi-Stim unity for a ninety (90) day rental:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy.

**Decision rationale:** As per MTUS guidelines "Interferential Current Stimulation is recommended only in conjunction with physical therapy, pain medications and return to work." There is negative or no evidence for use in the shoulder or for post-operative pain. There is some limited data in its use for low back pain. MTUS states that it may be used if there is failure of conservative treatment with medication, physical therapy and a positive 1 month trial. Galvanic Stimulation is not recommended. It is investigational and has limited evidence of utility. TENS(Transcutaneous Electrical Nerve stimulation) has some benefit in pain management and has evidence of benefit. As per the physician's addendum response dated 12/12/13, the surgi-stim was suppose to be part of patient's post-operative combined therapy used in conjunction with physical therapy and medication therapy. However as per MTUS guidelines, Interferential Current Stimulation has specific use criteria and needs to have a documented successful 1month trial of the inferential unit before a longer rental period can be approved. I agree that the device may be beneficial but as per guidelines, the current 90 day rental request does not meet criteria for approval. While TENS is recommended, this requested device is not a specific TENS device and has 2 non-recommended functions. The 90 day rental day period is not recommended.

**Coolcare cold therapy unit for a ninety (90) day rental:** 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).

**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 Section.

**Decision rationale:** As per the Official Disability Guidelines (ODG), Continuous-flow therapy is an option for post-operative swelling and inflammation for use up to 7days. As per the physicians' response of 12/12/13 states that he believes that the device will be beneficial but does not seem to argue to any longer term rental and provide similar citations supporting a 7day rental course. As per prior review, I agree with the modification to 7day rental period of the device but the professional opinion does not alter the evidence and guidelines do not support a longer rental period. The current request for 90 day rental period is not recommended.