

<b>Case Number:</b>	CM13-0033742		
<b>Date Assigned:</b>	12/06/2013	<b>Date of Injury:</b>	12/16/2010
<b>Decision Date:</b>	02/10/2014	<b>UR Denial Date:</b>	09/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/10/2013

### 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 Family Practice 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 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:

The patient is a 50 year old male who reported an injury on 12/16/2010. The mechanism of injury information was not provided in the medical record. The patient's diagnoses included left shoulder rotator cuff tear, left shoulder AC joint arthrosis, left shoulder impingement syndrome, and left shoulder synovitis. The patient medication regimen included ibuprofen 800mg, and omeprazole 20mg. The frequency of these medications was not provided in the medical record. Review of the medical record revealed the patient underwent left shoulder rotator cuff repair CPT Code 29827, arthroscopic AC joint arthroplasty CPT Code 29824, arthroscopic subacromial decompression CPT Code 29826, and arthroscopic extensive debridement including synovectomy and removal of loose bodies CPT Code 29823 on 08/29/2013 by [REDACTED], [REDACTED]. Most recent clinical note dated 09/06/2013 reported there were no signs of infection to surgical site, and the patient was to continue physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Everice unit times fourteen (14) days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cigna Government Services, Region D DMERC, Local Medical Review Policy.

**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:** Official Disability Guidelines states that continuous-flow cryotherapy is not recommended for nonsurgical treatment. They can be used post surgically for up to 7 days. The patient's documented surgery was on 08/29/2013, and the requested length of time of use exceeds the recommended time frame by ODG. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries has not been fully evaluated. The medical necessity for the use of a cryotherapy unit at this time for the requested length of time, which again exceeds the 7 days recommended by ODG has not been proven. As such, the request for Everice unit times fourteen (14) days is non-certified.

**for Everice left shoulder wrap times fourteen (14) days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cigna Government Services, Region D DMERC, Local Medical Review Policy.

**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 requested service works in conjunction with the requested Everice unit which is being non-certified, as such there is no medical necessity for the requested service. Therefore, the request for Everice left shoulder wrap times fourteen (14) days is non-certified.

**Transcutaneous Electrical Nerve Stimulation (TENS) 4-lead times five months modified to one month only:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrical nerve stimulation (TENS)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116.

**Decision rationale:** California MTUS states criteria for use of TENS unit beyond the one month trial requires documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial, a treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted, and other ongoing pain treatment should also be documented during the trial period including medication usage. There is none of the required documentation provided in the medical record, and as such the medical necessity for the usage of the TENS unit outside of the one month trial period has not been medically necessary. The previously modified

certification stands true. Therefore, the request for Transcutaneous Electrical Nerve Stimulation (TENS) 4-lead times five months is non-certified.