

<b>Case Number:</b>	CM13-0046650		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	09/23/2009
<b>Decision Date:</b>	04/25/2014	<b>UR Denial Date:</b>	10/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/01/2013

### 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 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:

The patient is a 64 year old male who was injured on 09/23/2009 while he was working as a truck loader/unloader and strained his left shoulder, pulling 1000 pounds of bulk candy on a daily basis. Prior treatment history has included physical therapy, cortisone injections, oral anti-inflammatory and analgesic medications. Diagnostic studies reviewed include MRI scan of the left shoulder performed on 02/20/2012 revealed posterior labral tear, subacromial impingement and acromioclavicular joint degenerative disease. Comprehensive Orthopedic Consultation dated 08/09/2013 documented the patient to have complaints of persistent left shoulder pain, tenderness, stiffness, swelling and weakness. The patient reports ongoing left shoulder pain at 8/10. Objective findings on examination of range of motion revealed: Left: forward flexion 160, extension 50, abduction 160; adduction 50; external rotation 90; and internal rotation 60. There is severe supraspinatus tenderness on the left, moderate greater tuberosity on the left and mild biceps tendon tenderness. There is also mild AC joint tenderness and positive subacromial crepitus. Examination of the left shoulder also revealed negative dislocation, subluxation, and laxity; muscle strength and tone of the left shoulder revealed forward flexion 4/5; abduction 4/5; external rotation 4/5; and internal rotation 4/5. The left shoulder is painful with movement. The distal sensation is normal to light touch bilaterally; reflexes are 2+ bilaterally in biceps, triceps and brachioradialis. The cervical spine revealed full range of motion. The left shoulder tested positive AC joint compression test impingement I (passive forward elevation in slight internal rotation), positive impingement II (passive internal rotation with 90 degrees of flexion), and positive impingement II (90 degrees active abduction-classic painful arc). The patient was diagnosed with left shoulder impingement syndrome, acromioclavicular joint degenerative disease and labral tear; and Status postindustrial injury on 09/23/2009.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**CPM unit for a 30-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 Shoulder Chapter regarding CPM, and Knee and Leg regarding 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:** According to the Official Disability guidelines, continuous passive motion (CPM) is recommended for adhesive capsulitis but not for shoulder labral tears or rotator cuff problems. The evidence based guidelines do not support use of a CPM device for this patient's diagnosis. The requested CPM rental is not supported; the medical necessity of this request has not been established.

**CPM soft goods for purchase:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the CPM device is not medically necessary, none of the associated products are medically necessary.

**IF unit for a 1 month rental, to include the purchase of 1 pack sterile foam electrodes, 3 packs of non-sterile 2 round electrode, 1 lead wire, 12 power packs, 16 adhesive remover towel mint, and a technical fee:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-119.

**Decision rationale:** According to the guidelines, interferential stimulation is not generally recommended as there is no evidence supporting or establishing efficacy in this form of treatment. The medical records do not establish this patient has any of the above listed criteria such as history of substance abuse or significant postoperative pain, or ineffective pain control with medications due to significant side effects. The medical records do not establish that rental of an IF unit and purchase of accessory equipment is appropriate and medically necessary for the management of this patient's shoulder complaint.

