

<b>Case Number:</b>	CM13-0048450		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	06/04/2010
<b>Decision Date:</b>	03/27/2014	<b>UR Denial Date:</b>	11/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2013

### 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 Orthopedic Surgery and is licensed to practice in Pennsylvania. 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 claimant is a 56-year-old gentleman with a date of injury of 6/4/10, secondary to repetitive motion. The accepted injury is shoulder pain and the claimant was noted to be status post shoulder surgery times two (2). Based upon the records provided for review, the first shoulder surgery on 6/5/10 was shoulder arthroscopy with rotator cuff repair by [REDACTED]. Documentation indicated that the claimant has had continued symptoms in the right shoulder and revision arthroscopic surgery has been recommended. It appears that the surgery has been deemed certified by the initial reviewer as well as preoperative clearance and seven post-operative physical therapy visits. The Initial reviewed determined that the request for post-operative use of a continuous passive motion (CPM) device, post-operative use of surgi-stim unit, and post-operative use of ninety (90) day rental of a cold therapy unit were not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Postoperative continuous passive motion (CPM) rental for forty-five (45) days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Guidelines.

**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 machine.

**Decision rationale:** The Official Disability Guidelines do not recommend the use of the continuous passive motion (CPM) device for post-operative shoulder management, particularly for subacromial decompression or rotator cuff repair. There is no medical evidence to demonstrate the difference in function or pain with the use of CPM utilization in addition to post-operative physical therapy. As such, the request for a post-operative CPM would be deemed medically unnecessary in this case.

**Postoperative Surgi-Stim unit rental for ninety (90) days:** Upheld

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

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

**Decision rationale:** The Chronic Pain Guidelines do not recommend the utilization of electrical stimulation as an isolated therapeutic modality. There is lack of documentation in the medical records provided as to whether this has been attempted previously and whether there has been any functional improvement. Also, from an orthopedic perspective, the unit has not been shown effective. As such, the utilization of the post-operative surgi-stim unit would not be deemed medically reasonable in this case based on current guideline recommendation.

**Postoperative cold care therapy unit rental for ninety (90) days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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.

**Decision rationale:** The Official Disability Guidelines recommend the utilization of post-operative cold therapy up to seven (7) days. It is also evident in the guidelines that cryotherapy units have been proven to help decrease pain, inflammation, and swelling as well as narcotic utilization. This request is for a ninety (90) day rental of a cold therapy unit, which exceeds the guideline recommended timeframe for use, and cannot be supported as medically necessary.