

<b>Case Number:</b>	CM13-0050430		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	02/20/2008
<b>Decision Date:</b>	04/29/2014	<b>UR Denial Date:</b>	11/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/13/2013

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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:

This patient is a 45-year-old female with date of injury 02/20/2009. Per treating physician's report 09/05/2013, the patient presents with neck and shoulder pain following a work-related injury, trip involved. MRI of the right shoulder from 12/20/2011 showed small partial rotator cuff tear with moderate degeneration of the AC joint. The patient has failed to improve conservative care, and the patient was being recommended for surgery. Examination showed diminished range of motion of the right shoulder with flexion at 155 degrees, extension 30 degrees, and abduction at 158 degrees. Diagnosis was right shoulder parascapular myofascial strain with MRI evidence of partial rotator cuff tear; status post left shoulder arthroscopic surgery, cervical musculoligamentous strain/sprain, thoracic spine musculoskeletal sprain/strain, lumbosacral musculoskeletal sprain/strain, and complaints of anxiety and depression. There is a utilization review letter dated 11/05/2013 authorizing the arthroscopic right shoulder evaluation and decompression.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**COOLCARE COLD THERAPY UNIT RENTAL FOR 90 DAYS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG SHOULDER CHAPTER, COLD/HEAT PACKS

**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:** This patient has been authorized for shoulder arthroscopic surgery. The request is for CoolCare cold therapy for 90 days. ODG Guidelines only allows 7 days for postoperative use and recommendation is for denial.

**PRE-OPERATIVE MEDICAL CLEARANCE:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Preoperative Testing General

**Decision rationale:** This patient is authorized for shoulder surgery, and the treater has asked for preoperative medical clearance. Recommendation is for authorization given the surgery that is already authorized. The utilization reviewer denied this request stating that there were no risk factors documented. However, medical evaluation including some basic labs and studies are supported by ODG Guidelines prior to surgical intervention such as urinalysis, electrolytes, and creatinine testing, glucose testing, etc. Recommendation is for authorization.

**CONTINUOUS PASSIVE MOTION (CPM) DEVICE RENTAL 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 Chapter (Web), Continuous Passive Motion (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 Chapter (Web), Continuous Passive Motion (CPM).

**Decision rationale:** This patient is cleared for arthroscopic surgery to repair rotator cuff. The treating physician has asked for CPM machine. However, ODG Guidelines does not support CPM units for shoulder and recommendation is for denial.

**SURGI-STIM UNIT RENTAL FOR 90 DAYS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation (NMES)..

**Decision rationale:** This patient is being scheduled for shoulder arthroscopic surgery. The request was for Surgi-Stim unit to help with postoperative pain. MTUS does not support use of neuromuscular electrical stimulation. MTUS states that this is primarily used as a part of rehabilitation program following stroke, and there is no evidence to support its use in chronic pain. Recommendation is for denial.