

<b>Case Number:</b>	CM13-0051648		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	06/20/2011
<b>Decision Date:</b>	05/09/2014	<b>UR Denial Date:</b>	11/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/14/2013

### 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 and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 62-year-old male who reported an injury on 06/20/2011. The mechanism of injury was a continuous trauma. The documentation of 10/18/2013 revealed the injured worker had necessity for shoulder surgery. The treatment plan included preoperative medical clearance, postoperative rehabilitative therapy, CPM device for 45 days to assist in restoring motion, CPM, and a Surgistim unit for 90 days, as well as a Coolcare cold therapy unit. The requested surgery was approved. The diagnosis included right shoulder impingement.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **PROSPECTIVE REQUEST FOR 45 DAYS RENTAL OF A CPM DEVICE BETWEEN 10/31/13 AND 1/29.2014: 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 (Acute & Chronic).

**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, Cpm.

**Decision rationale:** The Expert Reviewer's decision rationale: Official Disability Guidelines recommend the use of a continuous passive motion device for adhesive capsulitis. The clinical documentation submitted for review failed to indicate the injured worker had adhesive capsulitis. There was a lack of documentation of exceptional factors. Given the above, the prospective request for 45 days' rental of a CPM device between 10/31/2013 and 01/29/2014 is not medically necessary.

**PROSPECTIVE REQUEST FOR 90 DAY RENTAL OF SURGI-STIM UNIT BETWEEN 10/31/13 AND 1/29/14: 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 NMES/Interferential Current Stimulation/Galvanic Stimulation Page(s): 121, 118.

**Decision rationale:** The Expert Reviewer's decision rationale: California MTUS Guidelines do not recommend neuromuscular electrical stimulation (NMES devices) as there is no evidence to support its' use in chronic pain. They do not recommend interferential current stimulation (ICS) as an isolated intervention and galvanic stimulation is considered investigational for all indications. It is characterized by high voltage, pulsed stimulation and is used primarily for local edema reduction through muscle pumping and polarity effect and is not recommended. The clinical documentation submitted for review fails to provide documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the prospective request for 90 days' rental of Surgistim unit between 10/31/2013 and 01/29/2014 is not medically necessary.

**PROSPECTIVE REQUEST FOR 1 COOLCARE COLD THERAPY UNIT BETWEEN 10/31/13AND 1/29/14: 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 (Acute & Chronic).

**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 Expert Reviewer's decision rationale: Official Disability Guidelines recommend continuous-flow cryotherapy postoperatively for up to 7 days. There was lack of documentation indicating necessity for 90 days of use. Given the above, the prospective request for 1 Coolcare cold therapy unit between 10/31/2013 and 01/29/2014 is not medically necessary.