

<b>Case Number:</b>	CM13-0056461		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	09/12/2012
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	11/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/22/2013

### 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, has a subspecialty in Orthopedic Sports Medicine, 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 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 46 year old female whose date of injury is 9/12/12. The mechanism of injury is repetitive work. The injured worker was treated conservatively with physical therapy and injections. On 03/11/13, the injured worker underwent right shoulder arthroscopy with debridement of the rotator cuff and a glenoid labrum tear, and acromioplasty. The injured worker has subsequently been authorized for right shoulder arthroscopic acromioplasty.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **45 DAY POSTOPERATIVE USE OF A CONTINUOUS PASSIVE MOTION (CPM)**

**UNIT:** Upheld

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

**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

**Decision rationale:** The injured worker has been authorized for right shoulder arthroscopic acromioplasty. The Official Disability Guidelines (ODG) note that continuous passive motion is not recommended for rotator cuff problems, but as an option for adhesive capsulitis. This injured

worker does not meet the criteria for a CPM unit. As such, the request is not medically necessary.

**90 DAY POSTOPERATIVE USE OF A SURGI-STIM UNIT: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TENS - TRANSCUTANEOUS ELECTROTHERAPY, 114-117

**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, Transcutaneous electrical nerve stimulation

**Decision rationale:** The Official Disability Guidelines note that TENS units are recommended post-stroke to improve passive humeral lateral rotation, but there is limited evidence to determine if the treatment improves pain. For other shoulder conditions, TENS units are not supported by high quality medical studies. As such, the request is not medically necessary.

**POSTOPERATIVE USE OF A COOLCARE COLD THERAPY UNIT: Upheld**

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

**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 injured worker has been authorized to undergo right shoulder acromioplasty and was authorized for seven days postoperative use of a cold therapy unit. The Official Disability Guidelines support up to seven days of postoperative use, and there is no clear rationale provided to support exceeding this recommendation. Furthermore, there is no clear length of treatment outlined in the request. As such, the request is not medically necessary.