

<b>Case Number:</b>	CM13-0060643		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	04/28/2010
<b>Decision Date:</b>	08/21/2014	<b>UR Denial Date:</b>	11/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/03/2013

### **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:

This is a 63-year-old female who injured the left shoulder on 4/28/10. The records provided for review document that, following a course of conservative care, the recommendation for left shoulder arthroscopy, revision, subacromial decompression, distal clavicle resection, and labral debridement and repair was made. There is currently no indication of the surgical process being certified by carrier or that the surgical process has occurred. There are currently preoperative requests for use of a cryotherapy unit for purchase, surgical stim unit for ninety days, continued passive motion machine for 45 days, and preoperative medical clearance.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Pre-operative medical clearance:** 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7 Independent Medical Examinations and Consultations, page 127.

**Decision rationale:** Based on California ACOEM Guidelines, preoperative medical clearance would not be indicated. The records in this case indicate the recommendation for left shoulder surgical arthroscopy but it is not clear whether the procedure has been deemed medically necessary by the insurance carrier. A lack of documentation of the surgical process being supported would fail to support the need for preoperative medical clearance. Given the above the request is not medically necessary.

**Home Continuous Passive Motion Device for initial period of forty-five (45) Days:** 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) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - Continuous passive motion (CPM) Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. See the Knee Chapter for more information on continuous passive motion devices.

**Decision rationale:** The CA MTUS and ACOEM Guidelines do not address this request. The Official Disability Guidelines do not recommend the use of a continuous passive motion device following a shoulder arthroscopy. ODG Guidelines only recommend the role of CPM. Therefore the request is not medically necessary.

**Surgi-stim unit for initial period of ninety (90) days:** 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 : Interferential Current Stimulation (ICS) Page(s): 118-121.

**Decision rationale:** MTUS Chronic Pain Guidelines would not support ninety day use of a Surgi-Stim unit. Surgi-Stim units are a combination of interferential stimulation and neuromuscular electrical stimulation. According to the Chronic Pain Guidelines, neuromuscular electrical stimulation has no documented benefit in the acute or chronic pain setting. It is typically utilized for post-diagnostic care of stroke. It's role in the per operative setting would not be supported. Therefore is not medically necessary.

**Coolcare Cold Therapy unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205, 555-556.

**Decision rationale:** California ACOEM Guidelines, and supported by Official Disability Guidelines, would not support the role of a Cool Care cold unit. The need for operative intervention in this case has not been established thus negating the need for post-operative cryotherapy. Therefore the request is not medically necessary.