

<b>Case Number:</b>	CM13-0063761		
<b>Date Assigned:</b>	06/09/2014	<b>Date of Injury:</b>	07/26/2011
<b>Decision Date:</b>	12/31/2014	<b>UR Denial Date:</b>	11/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/10/2013

### 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 and Rehabilitation 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:

The patient is a 60 year old female with date of injury 07/26/11. The 10/9/13 treating physician report states that the patient is scheduled for arthroscopy of the right shoulder with rotator cuff repair on 11/12/13. The treating physician notes that the MRI scan shows large full thickness tear of the rotator cuff. Examination findings reveal tenderness of the right shoulder with weakness to external rotation. The current diagnoses are: 1. Cervical spine sprain/strain2. Rotator cuff tear3. Lumbar spine musculoligamentous strain4. Lumbar spine disc disease5. Lumbar spine radiculopathy6. Right knee sprain/strainThe utilization review report dated 11/13/13 denied the request for Cold Therapy Unit Purchase, SS4 Electrical Stim Unit Purchase, Pain Pump Purchase, and CPM 2 week rental based on lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold Therapy Unit Purchase:** 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)- TWC; ODG Treatment; Integrated Treatment/ Disability Duration Guidelines, Shoulder Chapter

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

**Decision rationale:** The patient presents with pain to the lumbar spine and shoulder region. The current request is for Cold Therapy Unit Purchase. The ODG guidelines recommended the usage of a continuous-flow cryotherapy unit as an option after surgery for up to 7 days, but not for non-surgical treatment. In this case the treating physician indicates that the patient presents for pre-operative surgical instructions and prescriptions were given for post-surgical treatment. The ODG guidelines only suggest this method once surgery has been completed and only for 7 days, not for purchase and long term usage. Recommendation is for not medically necessary.

**SS4 Electrical Stim Unit Purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-117.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

**Decision rationale:** The patient presents with pain to the lumbar spine and shoulder region. The current request is for SS4 Electrical Stim Unit Purchase. The MTUS Guidelines do not recommend interferential current stimulation (ICS). MTUS goes on to say that if ICS is decided to be used the criteria should be based on after effectiveness is proven by a physician or licensed provider of physical medicine when chronic pain is ineffectively controlled with medications, history of substance abuse or from significant post-operative conditions. In this case the treating physician is requesting purchase. There is no documentation of the results of a prior trial. Purchase is not warranted. Recommendation is for not medically necessary.

**Pain Pump Purchase:** 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)- TWC; ODG Treatment; Integrated Treatment/ Disability Duration Guidelines, Shoulder Chapter , Post Operative Pain Pump

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

**Decision rationale:** The patient presents with pain to the lumbar spine and shoulder region. The current request is for Pain Pump Purchase. The ODG guidelines do not recommend post-operative pain pump usage as a course of treatment. The MTUS guidelines are silent regarding this request. In the treating physician's report dated 10/9/13 the treating physician states, "Please authorize this equipment as it is a medical necessity for the post-operative recovery." There is no additional medical information provided to indicate why a post-operative pain pump that is not supported by the ODG is needed. Recommendation is for not medically necessary.

**CPM 2 Week Rental:** 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)- TWC; ODG Treatment ; Integrated Treatment/ Disability Duration Guidelines, Shoulder Chapter

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

**Decision rationale:** The patient presents with pain to the lumbar spine and shoulder region. The current request is for CPM 2 Week Rental. The MTUS Guidelines do not address CPM treatment. The ODG guidelines for continuous passive motion machines state, "Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Not recommended after shoulder surgery or for nonsurgical treatment." While the treating physician may feel that the usage of a CPM unit is appropriate for the patient, the guidelines do not support this request except in the case of adhesive capsulitis. Recommendation is for not medically necessary.