

<b>Case Number:</b>	CM14-0002243		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	07/07/1995
<b>Decision Date:</b>	07/07/2014	<b>UR Denial Date:</b>	12/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2014

### 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 injured worker is a 56-year-old female who reported an injury on 07/07/1995; the mechanism of injury was listed as a repetitive use injury. Within the medical record dated 12/03/2013, it was noted to be revealed that the injured worker complained of left shoulder pain and weakness due to a rotator cuff tear. The physical exam revealed that there was tenderness over the anterior lateral aspect of the left shoulder with passive forward flexion at 160 degrees. The exam further revealed that there was a positive impingement sign with weakness and pain elicited when testing the supraspinatus tendon against resistance. The injured worker's diagnoses include left shoulder complete tear of rotator cuff, status post right middle finger trigger finger release, right shoulder impingement syndrome, anxiety and depression, sleep disturbance, fibromyalgia, left knee arthritis and status post circumferential fusion. The injured worker's medication list included Norco 5/325 twice a day, Ambien 10 mg once at night and Prilosec 20 mg once a day. Within the supplemental report dated 12/19/2013, it should be noted that the injured worker was scheduled to do an open left rotator cuff repair on 01/20/2014. The Request for Authorization was not provided within the submitted medical records.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**THIRTY (30) SESSIONS OF POST OP PHYSICAL THERAPY: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines  
Page(s): 2-3.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10-27.

**Decision rationale:** The request for 30 sessions of postop physical therapy is non-certified. The California MTUS Guidelines state that for the postsurgical treatment guidelines, the definition of the initial course of therapy means 1/2 of the number of visits specified in the general course of therapy for a specific surgery in the postsurgical physical medicine treatment recommendations. Furthermore, the guidelines specify that for rotator cuff syndrome/impingement syndrome, the postsurgical treatment for an open resection of the shoulder be 30 visits over 18 weeks with a postsurgical physical medicine treatment period of no longer than 6 months. This would constitute an initial trial period to be assessed at 15 sessions, recommended to have the injured worker re-evaluated to assess for objective functional gains. With the request asking for the full treatment period and not allowing for an initial course of therapy, the request at this time cannot be supported by the guidelines. As such, the request is non-certified

**SIX (6) WEEKS CRYOTHERAPY UNIT RENTAL:** 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 Shoulder, Continuous-flow cryotherapy.

**Decision rationale:** The request for 6 weeks of a cryotherapy unit rental is non-certified. The Official Disability Guidelines recommend continuous flow cryotherapy after surgery, but not for nonsurgical treatment. Postoperative use generally may be for up to 7 days, including home use. The given request is for 42 days of utilization of a cryotherapy unit in the postsurgical utilization period. With the request exceeding the 7 day recommendation from the guidelines, the current request for a cryotherapy unit for 6 weeks cannot be supported by the guidelines at this time. As such, the request is non-certified.

**SIX (6) WEEKS SURGI STIM UNIT RENTAL:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION Page(s): 118-119.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117.

**Decision rationale:** The request for 6 weeks of a SurgiStim unit rental is non-certified. The Official Disability Guidelines do not recommend transcutaneous electrical nerve stimulation as a primary treatment modality, but a 1 month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. Furthermore, the guidelines detail the utilization of transcutaneous electrical nerve stimulation for postoperative pain as a recommended treatment option for acute postoperative

pain in the first 30 days postsurgery. Additionally, the guidelines recommend that the proposed necessity of the unit should be documented upon request. Within the submitted medical records, there was no documentation expressing the necessity for the use of a transcutaneous electrical nerve stimulation unit, and the request for a 6 week utilization of the unit exceeds the guideline recommendations. Without documentation outlying the necessity of the unit and documentation of extenuating circumstances that would necessitate a 6 week rental of a SurgiStim unit that would show a medical necessity exceed the guidelines, the request cannot be supported by the guidelines at this time. As such, the request is non-certified.

**FOUR (4) WEEKS SHOULDER CPM RENTAL: 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 Shoulder, Continuous passive motion (CPM).

**Decision rationale:** The request for 4 weeks of a shoulder CPM rental is non-certified. The Official Disability Guidelines do not recommend continuous passive motion for rotator cuff problems, but recommend it as an option for adhesive capsulitis for up to 2 weeks at 5 days per week. The guidelines further state that for rotator cuff tears, continuous passive motion is not recommended after shoulder surgery or for nonsurgical treatment. Without the guidelines supporting a recommendation for a continuous passive motion rental for postsurgical rotator cuff problems, the request cannot be supported at this time by the guidelines. As such, the request is non-certified.