

<b>Case Number:</b>	CM14-0002423		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	11/04/2011
<b>Decision Date:</b>	06/11/2014	<b>UR Denial Date:</b>	12/27/2013
<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 Illinois. 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 57 year old female with a reported cumulative injury dated 11/04/2010 to 11/04/2011. A progress note dated 11/18/2013 reported an MR arthrogram of the left shoulder was obtained revealing a full-thickness rotator cuff tear. The injured worker reported her pain at a 9/10. A progress note dated 12/05/2013 reported the claimant was an excellent candidate for left shoulder arthroscopic evaluation, arthroscopic decompression, distal clavicle resection, and rotator cuff repair and/or biceps tendon tenotomy versus tenodesis. A report dated 02/17/2014 listed the diagnoses as cervical spine sprain and strain with bilateral upper extremity radiculopathy, 3-4 millimeter disc extrusion, stenosis at C5-6, thoracolumbar sprain and strain with right lower extremity radiculopathy, facet osteoarthritis at L3 through S1, bilateral elbow medial and lateral epicondylitis, bilateral wrist tendinitis, De Quervain's and moderate carpal tunnel syndrome, bilateral shoulder sprain and strain with bursitis, calcific tendinitis and impingement, right hip bursitis and aggravation of diabetes mellitus, lupus, stress, and anxiety. The request for authorization form dated 11/18/13 was for CPM machine and Surgi-Stim unit for post-operative use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CONTINUOUS PASSIVE MOTION (CPM) DEVICE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder, Continuous Passive Motion (CPM).

**Decision rationale:** The Official Disability Guidelines (ODG) do not recommend a continuous passive motion machine for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Additionally, the ODG guidelines do not recommend a continuous passive motion machine after shoulder surgery or for nonsurgical treatment. ODG guidelines state that the evidence on the comparative effectiveness and the harms of various operative and non-operative treatments for rotator cuff tears is limited and inconclusive. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain, and one study found no difference in range of motion or strength. Furthermore, ODG guidelines do not recommend a CPM machine for shoulder rotator cuff surgeries. In this case, there is no indication the proposed surgery has been authorized or completed to date. Furthermore, the request does not include the duration of use. Therefore, the request for continuous passive motion (CPM) device is not medically necessary and appropriate.

**SURGI-STIM UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Post-Operative Pain Page(s): 116.

**Decision rationale:** The California Chronic Pain Medical Treatment guidelines recommend a TENS unit as a treatment option for acute post-operative pain in the first 30 days post-surgery. TENS units appear to be most effective for mild to moderate thoracotomy pain. The MTUS guidelines state it has been shown to be of lesser effect, or not at all for other orthopedic surgical procedures. The MTUS guidelines also recommend a 30 day trial. In this case the patient is waiting for surgical approval to their shoulder and the guidelines recommend TENS units for thoracotomy pain. In addition, there is no indication the proposed surgery has been authorized or completed to date, and the request does not include the duration of use. Therefore, the request for a Surgi-Stim unit is not medically necessary and appropriate.