

<b>Case Number:</b>	CM14-0042044		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	04/24/2012
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	03/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/09/2014

### 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 & Rehabilitation, has a subspecialty in Pain Management 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 male patient with the date of injury of April 24, 2012. A Utilization Review was performed on March 7 2014, recommended modification of post-op DME cold therapy unit and non-certification of pain pump, electrical stimulator (orthostim and supplies), and a continuous passive motion (CPM) machine. There is note that the patient underwent diagnostic and operative arthroscopy of the left shoulder with acromioplasty, a Mumford procedure, lysis of adhesions with subacromial bursectomy, partial synovectomy ,removal of loose bodies and the insertion of a pain pump in the subacromial space on January 21, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**post - op cold therapy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, shoulder cryotherapy.

**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 section.

**Decision rationale:** Regarding the request for post-op cold therapy, ODG cites that continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use, but not for non-surgical treatment. Within the documentation available for review, there is no indication as to how many days of post-op use are requested, therefore making this an open-ended request. Unfortunately, there is no provision in place to modify the request to 7 days, as recommended by guidelines. As such, the currently requested post-op cold therapy is not medically necessary.

**post -op pain pump:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines shoulder: post op.

**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, Postoperative pain pump.

**Decision rationale:** Regarding the request for post-op pain pump, California MTUS does not address the issue. ODG cites that postoperative pain pumps are not recommended for the shoulder, as there is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures. In light of the above issues, the currently requested post-op pain pump is not medically necessary.

**electrical stimulator:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines shoulder electrical stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 114-121 of 127.

**Decision rationale:** Regarding the request for electrical stimulator, this unit is a combination electrical stimulation unit which includes TENS, interferential current, galvanic stimulation, and neuromuscular stimulation. In order for a combination device to be supported, there needs to be guideline support for all incorporated modalities. The guidelines state that TENS is not recommended as a primary treatment modality, but a one 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. The guidelines go on to state the galvanic stimulation is not recommended. Additionally, guidelines state that interferential current stimulation is not recommended as an isolated invention except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Finally, guidelines state that neuromuscular electrical stimulation is not recommended. Within the documentation available for review, there is no indication that the patient is failed a TENS unit trial, as recommended by guidelines prior to an

interferential unit trial. Additionally, there is no indication that the interferential current stimulation will be used as an adjunct to program of evidence-based rehabilitation, as recommended by guidelines. Furthermore, guidelines do not support the use of galvanic stimulation or neuromuscular stimulation. As such, the currently requested electrical stimulator is not medically necessary.

**orthostim supplies for electrical stimulator:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines shoulder electrical stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 114-121 of 127.

**Decision rationale:** Regarding the request for orthostim supplies for electrical stimulator, this unit is a combination electrical stimulation unit which includes TENS, interferential current, galvanic stimulation, and neuromuscular stimulation. In order for a combination device to be supported, there needs to be guideline support for all incorporated modalities. Chronic Pain Medical Treatment Guidelines state that TENS is not recommended as a primary treatment modality, but a one 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. Guidelines go on to state the galvanic stimulation is not recommended. Additionally, guidelines state that interferential current stimulation is not recommended as an isolated invention except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Finally, guidelines state that neuromuscular electrical stimulation is not recommended. Within the documentation available for review, there is no indication that the patient is failed a TENS unit trial, as recommended by guidelines prior to an interferential unit trial. Additionally, there is no indication that the interferential current stimulation will be used as an adjunct to program of evidence-based rehabilitation, as recommended by guidelines. Furthermore, guidelines do not support the use of galvanic stimulation or neuromuscular stimulation. As such, the currently requested orthostim supplies for electrical stimulator is not medically necessary.

**continuous passive motion machine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines shoulder chapter continuous passive motion.

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

**Decision rationale:** Regarding the request for continuous passive motion machine, California MTUS and ACOEM do not contain criteria for this treatment modality. ODG states continuous

passive motion is not recommended after shoulder surgery or for nonsurgical treatment. As such, the currently requested continuous passive motion machine is not medically necessary.