

<b>Case Number:</b>	CM14-0048556		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	05/26/1999
<b>Decision Date:</b>	07/28/2014	<b>UR Denial Date:</b>	03/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/28/2014

### 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 Geriatrics and is licensed to practice in New York. 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 53 year old woman with a date of injury of 5/26/99. She underwent a diagnostic an operative arthroscopy of the left shoulder with rotator cuff repair on 1/7/14. She was seen by her primary treating physician on 1/15/14 complaining of on and off pain in her shoulder with pain into her left elbow. Pain medications were helping with pain documented as 6/10. Her physical exam showed swelling, weakness and stiffness of the left shoulder with a well healing incision. Radiographs of the left shoulder and humerus showed no increase in osteoarthritis. At issue in this review are one electrical stimulation unit, one pain pump and one continous passive motion machine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) electrical stimulation unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder, Neuromuscular electrical stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 113-117.

**Decision rationale:** An electrical stimulation unit or TENS unit 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. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. In this injured worker, other treatment modalities are not documented to have been trialed and not successful. There is no indication of spasticity, phantom limb pain, post-herpetic neuralgia or multiple sclerosis which the TENS unit may be appropriate for. The medical necessity for one electrical stimulation unit is not substantiated in the records.

**One (1) pain pump:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 74-80.

**Decision rationale:** This 53 year old injured worker underwent arthroscopic shoulder surgery and rotator cuff repair. The MD visit of 1/14 documents that pain medications are helping her with pain at 6/10 currently. There is no medical justification or documentation of why a pain pump is indicated instead of oral medications which are effective. The medical records fail to justify the medical necessity of a pain pump.

**One (1) continuous passive motion (CPM) machine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-224.

**Decision rationale:** This 53 year old injured worker underwent arthroscopic shoulder surgery and rotator cuff repair. The MD visit of 1/14 documents that pain medications are helping her with pain at 6/10 currently. There is no medical justification or documentation of why a continuous passive motion machine is indicated instead of physical therapy for range of motion which has been ordered. The medical records fail to justify the medical necessity of a continuous passive motion machine.