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| <b>Case Number:</b>   | CM14-0065428 |                              |            |
| <b>Date Assigned:</b> | 07/11/2014   | <b>Date of Injury:</b>       | 07/29/2011 |
| <b>Decision Date:</b> | 09/25/2014   | <b>UR Denial Date:</b>       | 04/28/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/08/2014 |

### 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 Orthopedic Surgery, 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:

A 59 year old male injured worker with an industrial injury dated 07/29/11. Exam note dated 03/24/14 states the patient returns with stiffness and weakness of the left shoulder. The patient is status post left rotator cuff repair, decompression, and distal clavicle resection as of 11/13/13. Conservative treatments include 8 post-op physical therapy visits, and medications. Physical exam demonstrates the patient had 0-125 degrees of active forward flexion, forward elevation, and abduction. In addition, the patient had 55 degrees of external humeral rotation of the left shoulder, an abduction of 90 degrees, and 0 degrees of internal rotation. Diagnosis was noted as adhesive capsulitis of the left shoulder. Treatment included left shoulder arthroscopy, arthroscopic capsular release, and manipulation under anesthesia.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**E-stim unit for the left shoulder, fourteen (14) day rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, post operative pain (transcutaneous electrical nerve stimulation) Page(s): 116-117. Decision based on Non-MTUS Citation ODG, Shoulder, Electrical stimulation.

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

**Decision rationale:** ODG Guidelines; Shoulder Section, regarding electrical stimulation, states that electrical stimulation is not recommended. Therefore, based on guideline recommendations, the request is not medically necessary.

**CPM (continuous passive motion) unit for the left shoulder, thirty (30) day rental:**  
Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder, 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 Chapter, Continuous passive motion (CPM).

**Decision rationale:** According to the Official Disability Guidelines, CPM is recommended for patients with adhesive capsulitis but not for patients with rotator cuff pathology primarily. With regards to adhesive capsulitis it is recommended for 4 weeks. The patient has clear evidence of adhesive capsulitis. Therefore, the request is medically necessary..

**Left shoulder sling with large abduction pillow, purchase:** Upheld

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

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

**Decision rationale:** Per the ODG Guideline criteria, abduction pillows are recommended following open repair of large rotator cuff tears but not for arthroscopic repairs. In this case there is no indication of the need for open rotator cuff repair and therefore the request is not medically necessary.

**Cold therapy unit for the left shoulder, fourteen (14) day rental:** Upheld

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

**Decision rationale:** According to the ODG Shoulder Chapter, continuous flow cryotherapy is recommended immediately postoperatively for upwards of 7 days. In this case the request of 14

days exceeds the length of time recommended by the guidelines. Therefore the request is not medically necessary.