

<b>Case Number:</b>	CM14-0085546		
<b>Date Assigned:</b>	09/22/2014	<b>Date of Injury:</b>	05/23/2011
<b>Decision Date:</b>	01/05/2015	<b>UR Denial Date:</b>	05/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2014

### 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 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:

The patient is a 61-year-old male who has submitted a claim for bilateral rotator cuff tear status post right rotator cuff repair associated with an industrial injury date of 5/23/2011. Medical records from 2014 were reviewed. The patient complained of locking and popping of the right knee aggravated by bending, kneeling, stooping, standing, and walking. The patient likewise experienced bilateral shoulder pain rated 8/10 in severity. Physical examination of the left shoulder showed limited motion, tenderness, subacromial crepitus, weak muscles, normal sensory, intact reflexes, and positive impingement sign. Ultrasound of both shoulders from 3/2/2012 demonstrated right full thickness rotator cuff tear, right long head biceps tendon partial thickness tear, and right AC joint effusion. Treatment to date has included right rotator cuff repair, subacromial decompression and distal clavicle resection on 9/11/2013, acupuncture, physical therapy, Norco and Anaprox. Current treatment plan includes left shoulder arthroscopy, subacromial decompression and distal clavicle resection. The request for CPM is to restore motion. The request for multiple electrical stimulation unit is to assist in muscle re-education and to allow early return to activities of daily living. The utilization review from 5/7/2014 denied the request for postoperative home CPM device because guidelines do not routinely support its use after shoulder surgery and instead recommend a rehabilitative exercise program; and denied multiple electrical stimulation unit with interferential and neuromuscular and high volt pulsed current and pulsed direct current because there was no report that medications have been ineffective for the patient to warrant use of multiple electrical stimulation unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Postoperative home CPM device: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Integrated Treatment/Disability Duration Guidelines, Shoulder (Acute & Chronic)

**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:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines (ODG) Shoulder Chapter was used instead. ODG states that CPM is not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis. The guideline also does not support its use after shoulder surgery for rotator cuff tears or for non-surgical treatment. In this case, the patient is to undergo left shoulder arthroscopy, subacromial decompression and distal clavicle resection. The request for CPM is to restore motion. However, the guideline clearly states that CPM use for the patient's condition is not supported. The medical necessity has not been established. Therefore, the request for postoperative home CPM device is not medically necessary.

**Multiple electrical stimulation unit with interferential and neuromuscular and high volt pulsed current and: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Integrated Treatment/Disability Duration Guidelines, Shoulder (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS; Interferential Current Stimulator; Neuromuscular electrical stimulation Page(s): 114-116.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines page 114 discusses TENS as opposed to multiple other devices. It does not consistently recommend interferential and NMS, (pages 118 and 120). As noted on page 114 of the CA MTUS Chronic Pain Medical Treatment Guidelines, transcutaneous electrotherapy includes TENS, interferential current stimulation, microcurrent electrical stimulation, neuromuscular electrical stimulation, RS-4i sequential stimulator, electroceutical therapy, and sympathetic therapy. In this case, the patient is to undergo left shoulder arthroscopy, subacromial decompression and distal clavicle resection. The request for multiple electrical stimulation unit is to assist in muscle re-education and to allow early return to activities of daily living. However, there is no documentation of failure of medications that would necessitate an electrical stimulation unit. Moreover, there is no documentation of a rationale identifying why a combined electrotherapy unit would be required as opposed to a TENS unit. Likewise, it was not stated in the request whether the device is for purchase or for rental. Therefore, the request for multiple electrical stimulation unit with

interferential and neuromuscular and high volt pulsed current and pulsed direct current is not medically necessary.