MAXIMUS Federal Services

| Case Number: | CM15-0106854 | | |
|---|---|---|---|
| Date Assigned: | 06/11/2015 | Date of Injury: | 03/14/2014 |
| Decision Date: | 07/13/2015 | UR Denial Date: | 05/22/2015 |
| Priority: | Standard | Application Received: | 06/03/2015 |

## 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, Indiana, Oregon
Certification(s)/Specialty: Orthopedic Surgery

## 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 female, who sustained an industrial injury on 3/14/2014. She reported right shoulder pain. Diagnoses have included right forearm/wrist tenosynovitis and carpal tunnel syndrome, right shoulder sprain/strain and right shoulder impingement syndrome. Treatment to date has included physiotherapy and medication. According to the progress report dated 4/3/2015, the injured worker complained of pain in the right shoulder and right arm/hand. The pain was rated 8/10. The pain was associated with popping, swelling, giving way, fatigue and tingling. Exam of the shoulders revealed tenderness and decreased range of motion. Impingement test was positive. A diagnostic ultrasound of the right shoulder from 10/2/2014 revealed a partial-thickness supraspinatus tendon tear with chronic subacromial impingement. The treatment plan was for arthroscopic right shoulder decompression, distal clavicle resection and rotator cuff debridement and/or repair as needed. Authorization was requested for a post-operative continuous passive motion device, a surgi-stim unit and a cold therapy unit.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Postoperative continuous passive motion device (days) Qty: 45.00:** Upheld

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

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

**Decision rationale:** CA MTUS/ACOEM guidelines are silent on the issue of CPM machine. According to the Official Disability Guidelines, Shoulder Chapter, Continuous passive motion (CPM), CPM is recommended for patients with adhesive capsulitis but not with patients with rotator cuff pathology primarily. With regards to adhesive capsulitis it is recommended for 4 weeks. As there is no evidence preoperatively of adhesive capsulitis and to what extent it exists, the request exceeds guidelines, the determination is not medically necessary.

**Surgi-Stim unit (days) Qty: 90.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-117.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines interferential current Page(s): 118-119.

**Decision rationale:** Regarding the Interferential Current Stimulation (ICS), the California MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation, pages 118-119 state, "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues". As there is insufficient medical evidence regarding use in this clinical scenario, the determination is not medically necessary.

**Cold therapy unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter.

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for up to 7 days. In this case, there is no specification of length of time requested postoperatively for the cryotherapy unit. Therefore, the determination is not medically necessary.