

<b>Case Number:</b>	CM15-0106859		
<b>Date Assigned:</b>	06/11/2015	<b>Date of Injury:</b>	10/22/2012
<b>Decision Date:</b>	07/13/2015	<b>UR Denial Date:</b>	05/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	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 52-year-old, male who sustained a work related injury on 10/22/12. His injury occurred when he held out his left arm sideways to take documents from a customer. The diagnoses have included status postindustrial left shoulder injury, status post failed arthroscopic rotator cuff repair and possible partial rotator cuff tear. Treatments have included medications, physical therapy, cortisone injections, ice therapy, chiropractic treatments, left shoulder surgery and acupuncture. In the Comprehensive Orthopedic Consultation report dated 3/13/15, the injured worker complains of ongoing left shoulder pain with tenderness, stiffness, swelling and weakness. He states his pain level is 7-8/10. He describes the pain as dull, sharp and shooting. He has severe tenderness to palpation of left supraspinatus area and left acromioclavicular joint. He has mild tenderness to palpation of left biceps tendon. He has left subacromial crepitus. He has decreased range of motion in left shoulder. The treatment plan includes requests for shoulder surgery and postoperative durable medical equipment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home continuous passive motion device ( in days) Qty:45: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 (in days) Qty:90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines interferential current Page(s): 188-119.

**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 for indefinite use Qty:1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

