

<b>Case Number:</b>	CM15-0186532		
<b>Date Assigned:</b>	09/28/2015	<b>Date of Injury:</b>	01/20/2010
<b>Decision Date:</b>	11/03/2015	<b>UR Denial Date:</b>	08/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2015

### 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, Oregon, Washington  
 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 62 year old female, who sustained an industrial injury on January 20, 2010. The injured worker was diagnosed as having chronic subacromial impingement syndrome and status post left shoulder continuous trauma, January 20, 2010 through March 14, 2014, with ultrasound-confirmed subacromial impingement of the left shoulder. Treatment to date has included diagnostic studies, injections to the left shoulder, physical therapy (8 sessions) ordered on May 16, 2014, medications and work restrictions. It was noted on an August 30, 2011 report she had completed physical therapy with continued pain rated at 9 on a 1-10 scale. The number of sessions was unclear. Evaluation on May 9, 2015, revealed positive impingement of the left shoulder and tenderness to palpation with decreased range of motion. It was noted she had underwent her second steroid injection to the left shoulder on April 13, 2015 with no improvement. It was noted she had no improvement since the previous exam. Evaluation on July 20, 2015, revealed ongoing left shoulder pain, tenderness, stiffness and weakness despite physiotherapy, pain medications and cortisone injections x2 to the left shoulder. She rated her pain at 8 on a 1-10 scale with 10 being the worst. The left shoulder range of motion was noted as decreased. Tenderness to palpation and crepitus with movement of the left shoulder was noted. Surgical intervention of the left shoulder was recommended. The RFA included a request for Associated surgical service: Coolcare cold therapy unit that was modified and Associated surgical service: Home continuous passive motion (CPM) device; for an initial period of 45 days and Associated surgical service: Surgi-stim unit; for an initial period of 90 days that were non-certified on the utilization review (UR) on August 31, 2015.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: Home continuous passive motion (CPM) device; for an initial period of 45 days:** 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 Chapter, Continuous passive motion (CPM).

**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 in the cited records, the determination is for not medically necessary.

**Associated surgical service: Surgi-stim unit; for an initial period of 90 days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation <http://www.vqorthocare.com/products/surgistim-4/>.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

**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 for not medically necessary.

**Associated surgical service: Coolcare 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, 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) Cold compression therapy.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of cold compression therapy. According to the ODG, Cold compression therapy, it is not recommended in the shoulder as there are no published studies. It may be an option for other body parts such as the knee although randomized controlled trials have yet to demonstrate efficacy. As the guidelines do not recommend the requested DME, the determination is for not medically necessary.