

<b>Case Number:</b>	CM15-0038143		
<b>Date Assigned:</b>	03/06/2015	<b>Date of Injury:</b>	05/06/2009
<b>Decision Date:</b>	04/17/2015	<b>UR Denial Date:</b>	02/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/28/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 49-year-old female who sustained an industrial injury on 05/06/2009. Diagnoses include right shoulder rotator cuff tear. Treatment to date has included medications, physical therapy, injections, and home exercise program. A physician progress note dated 12/19/2014 documents the injured worker's right shoulder pain is rated 8-10 out of 10. Range of motion is decreased. She has severe supraspinatus tenderness. Magnetic Resonance Imaging done on 07/21/2014 revealed a full thickness rotator cuff, supraspinatus and infraspinatus tendon tear with acromioclavicular degenerative joint disease and subacromial impingement. Surgery has been approved. Treatment requested is for Coolcare Cold therapy unit for 90 days, Home Continuous Passive Motion device for 45 days, and Surgi-Stim Unit for 90 days. On 02/09/2015, Utilization Review modified the request for Coolcare Cold Therapy unit for 90 days to 7 days and cited was ODG. The request for Home Continuous Passive Motion device for 45 days was denied and cited was ODG. The request for Surgi-Stim Unit for 90 days was non-certified and cited was ODG.

### 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 for 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, Shoulder Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Shoulder Chapter, continuous passive motion devices.

**Decision rationale:** The patient presents with right shoulder pain rated 8-10 /10. The request is for HOME CONTINUOUS PASSIVE MOTION DEVICE FOR 45 DAYS. The RFA provided is dated 12/19/14. Patient's diagnosis included right shoulder rotator cuff tear. Patient is temporarily totally disabled. The ACOEM and MTUS do not discuss Continuous passive motion devices. ODG Shoulder Chapter has the following regarding continuous passive motion devices, "Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week." ODG further states, "Rotator cuff tears: Not recommended after shoulder surgery or for nonsurgical treatment." Treater is requesting for-home continuous passive motion machine to assist in restoring range of motion. The patient was diagnosed with right shoulder rotator cuff tear. MRI of the right shoulder on 07/21/14 revealed a full thickness rotator cuff, supraspinatus and infraspinatus tendon tear with acromioclavicular degenerative joint disease and subacromial impingement. ODG Guidelines do not recommend CPM for patients with shoulder rotator cuff problems. It is recommended for adhesive capsulitis but this patient does not present with this. Therefore, the requested continuous passive motion unit IS NOT medically necessary.

**Surgi-Stim Unit for 90 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, Shoulder Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120. Decision based on Non-MTUS Citation <http://www.vqorthocare.com/products/orthostim-4-surgistim-4/>.

**Decision rationale:** The patient presents with right shoulder pain rated 8-10 /10. The request is for SURGI-STIM UNIT FOR 90 DAYS. The RFA provided is dated 12/19/14. Patient's diagnosis included right shoulder rotator cuff tear. Patient is temporarily totally disabled. On line research shows that SurgiStim is a multi-modality interferential stimulator <http://www.vqorthocare.com/products/orthostim-4-surgistim-4/> MTUS pages 118 to 120 states that Interferential Current Stimulation (ICS) are not recommended as an isolated intervention. MTUS further states, "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway." It may be appropriate if pain is not effectively controlled due to diminished effectiveness or side effects of medication; history of substance abuse, significant pain due to postoperative conditions; or the patient is unresponsive to conservative measures. A one-month trial may be appropriate if the above criteria are met. SURGI-STIM UNIT is being requested post-operatively to assist in managing post-operative

swelling, edema, and pain and to assist in muscle re-education, and further to allow an earlier return to activities of daily living. MTUS recommends ICS not as an isolated intervention if there is significant pain due to postoperative conditions. The patient is authorized for surgery; however, guidelines state a 1-month trial may be appropriate and the request is for 90 days. The request IS NOT medically necessary.

**Coolcare Cold therapy unit for 90 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, Shoulder Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Shoulder chapter, continuous-flow cryotherapy.

**Decision rationale:** The patient presents with right shoulder pain rated 8-10 /10. The request is for COOLCARE COLD THERAPY UNIT FOR 90 DAYS. The RFA provided is dated 12/19/14. Patient's diagnosis included right shoulder rotator cuff tear. Patient is temporarily totally disabled. The MTUS and ACOEM guidelines do not specifically discuss Vascutherm units. Therefore, ODG Guidelines are referenced. ODG Guidelines under the Shoulder chapter has the following regarding continuous-flow cryotherapy: "Recommended as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated." The MTUS Guideline recommends the duration of postoperative use of continuous-flow cryotherapy to be 7 days. In this case, the treating physician has recommended 90-days, which exceeds the 7-day post-op use recommended by ODG guidelines. This request IS NOT medically necessary.