

<b>Case Number:</b>	CM15-0057955		
<b>Date Assigned:</b>	04/02/2015	<b>Date of Injury:</b>	07/29/2009
<b>Decision Date:</b>	05/14/2015	<b>UR Denial Date:</b>	03/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2015

### 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: Minnesota, Florida  
 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:

This 51 year old female sustained an industrial injury on 7/29/09. She subsequently reported injury to her neck, back, arms, shoulders, elbows, hands and wrists. Diagnostic testing has included ultrasound and MRIs. Diagnoses include bilateral wrist tendinitis. Treatments to date have included acupuncture, injections, carpal tunnel surgery, modified work duty and prescription pain medications. The injured worker continues to experience low back and bilateral upper extremity pain. A request for arthroscopic shoulder surgery was certified by utilization review. Associated requests for a CPM unit, surgi-stim unit and Coolcare cold therapy unit were modified or non-certified. These have now been appealed to an independent medical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CPM unit, 45 days (continuous passive motion): 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 ODG: Section: Shoulder, Topic: Continuous passive motion.

**Decision rationale:** ODG guidelines do not recommend continuous passive motion for shoulder rotator cuff problems but recommend it as an option for adhesive capsulitis. The documentation indicates evidence of impingement syndrome for which a subacromial decompression with possible rotator cuff debridement or repair was certified. The documentation does not indicate the diagnosis of adhesive capsulitis. As such, the request for continuous passive motion 45 days rental is not supported and the medical necessity of the request has not been substantiated.

**Surgi-Stim unit, 90 days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation (ICS) Page(s): 114-116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**Decision rationale:** The chronic pain medical treatment guidelines do not recommend galvanic stimulation as it is considered investigational for all indications. Interferential electrical stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with the recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Neuromuscular electrical stimulation is not recommended. It is used primarily as part of a rehabilitation program following a stroke and there is no evidence to support its use in chronic pain. As such, the request for Surgi Stim unit 90 days rental is not supported and the medical necessity of the request has not been substantiated.

**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: Shoulder chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Continuous flow cryotherapy.

**Decision rationale:** ODG guidelines recommend continuous-flow cryotherapy as an option after shoulder surgery. The generally recommended period of use is for 7 days after surgery. It reduces pain, inflammation, swelling, and the need for narcotics after surgery. Use beyond 7 days is not recommended. As such, the request for a cold therapy unit purchase is not medically necessary.