

<b>Case Number:</b>	CM14-0180188		
<b>Date Assigned:</b>	11/04/2014	<b>Date of Injury:</b>	03/24/2010
<b>Decision Date:</b>	12/16/2014	<b>UR Denial Date:</b>	10/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Fellowship trained in Pediatric Orthopedics and is licensed to practice in Texas and Colorado. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 male who reported an injury on 03/24/2010. The mechanism of injury was not submitted for review. The injured worker's diagnoses included right knee degenerative arthritis, left shoulder impingement, left shoulder rotator cuff tear, left acromioclavicular joint pain, left shoulder labral tear and left elbow lateral epicondylitis. The injured worker's medical treatment consists of injections, physical therapy, and medication therapy. No diagnostics were submitted for review. On 10/01/2014 the injured worker complained of left shoulder pain. Physical examination of the left shoulder revealed positive impingement sign. There was weakness with external rotation and abduction. There was pain over the biceps. It was also noted that there was pain over the acromioclavicular joint. There was no anterior/posterior instability. The medical treatment plan is for the injured worker to undergo left shoulder arthroscopy, subacromial decompression, repair of the labrum, and acromioclavicular joint decompression. The provider is request associated surgical service for a Polar care unit, CPM machine, and sling. The rationale and Request for Authorization form were not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: Polar care unit, left shoulder, purchase: 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 (updated 08/27/14)

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

**Decision rationale:** The request for associated surgical service: polar care unit, left shoulder, purchase is not medically necessary. The ODG do not recommend the use of cool compression therapy in the shoulder as there are no published studies. It may be an option for other body parts. The Game Ready device provides both active, continuous cold and intermittent pneumatic compression to the postop joint. There has been an RCT underway since 2008 to evaluate and compare clinical postoperative outcomes for patients using an active cooling and compression device, and those using ice packs and elastic wrap after acromioplasty or arthroscopic rotator cuff repair, but the results are not available. There was no indication in the submitted documentation that the injured worker had or was undergoing left shoulder surgery. Additionally, the ODG do not recommend the use of cold compression units for the shoulder. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.

**Associated surgical service: CPM, left shoulder, rental 21 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 (updated 08/27/14)

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

**Decision rationale:** The request for associated surgical service CPM, left shoulder, rental 21 days is not medically necessary. According to the ODG, continuous passive motion is not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Guidelines also state that recent Cochrane review concluded that there was high quality evidence that continuous passive motion increased passive range of motion and active flexion range of motion, but that these effects are too small to be clinically worthwhile and there is low quality evidence that continuous passive motion has no effect on length of hospital stay, but reduces the need for manipulation under anesthesia. The adjunct of home use CPM may be an effective treatment option for patients at risk for contractures, regardless of whether the patient is being treated as part of Workers' Compensation claim or not. Recent literature suggests that routine home use of CPM has minimal benefit when combined with standard physical therapy, but studies conducted in a controlled hospital setting suggest the CPM can improve rehabilitation. The submitted documentation did not indicate that the injured worker had undergone shoulder surgery, nor did it indicate that the injured worker was going to be receiving shoulder surgery. Additionally, there was no rationale submitted to

warrant the request. Given the lack of submitted documentation and that ODG do not recommend the use of CPM, the request is not medically necessary.

**Associated surgical service: sling, left shoulder, purchase:** 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 (updated 08/27/14)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

**Decision rationale:** The request for associated surgical service: sling, left shoulder, purchase is not medically necessary. The California MTUS/ACOEM Guidelines state that slings may be used only for brief use for severe shoulder pain (1 to 2 days with pendulum exercises to prevent stiffness in cases of rotator cuff conditions). The submitted documentation indicated that the injured worker had a diagnoses of left shoulder rotator cuff tear. However, the request as submitted is for a post-op purchase of a sling. There was no indication in the submitted documentation that the injured worker had undergone left shoulder surgery or that the injured worker was going to be undergoing left shoulder surgery. Additionally, the request as submitted and not specified duration of the sling and per guidelines the use of slings are only recommended for 1 to 2 days. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.