

<b>Case Number:</b>	CM15-0111631		
<b>Date Assigned:</b>	06/18/2015	<b>Date of Injury:</b>	04/01/2011
<b>Decision Date:</b>	07/22/2015	<b>UR Denial Date:</b>	06/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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: Texas, California  
 Certification(s)/Specialty: Family Practice

### 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 46-year-old female, who sustained an industrial injury on 4/1/11. She reported right shoulder pain and neck pain. The injured worker was diagnosed as having sprain/strain of right upper extremity with radiculopathy, right shoulder periscapular strain and tenosynovitis of biceps tendons. Treatment to date has included epidural steroidal injections, physical therapy, acupuncture sessions and activity restrictions. Currently, the injured worker complains of right shoulder pain, 90% improved with 2nd cervical epidural steroid injection. Physical exam noted tenderness to palpation of right periscapular area with restricted range of motion and positive impingement. A request for authorization was submitted for arthroscopic right shoulder decompression and distal clavicle resection, pre-operative medical clearance, post-operative rehabilitative therapy, home continuous passive motion device, shoulder immobilizer, coolcare cold therapy unit and Surgi-Stim unit. Per note dated 4/13/15 patient had complaints of right shoulder pain. Physical examination of the right shoulder revealed tenderness on palpation, limited range of motion, 4/5 strength and positive impingement sign. The patient has had MRI of the right shoulder on 3/31/14 that revealed supraspinatus tendinosis and MRI of the cervical spine on 6/12/10 that revealed degenerative disc disease. Patient had received cervical ESI for this injury. The current medication list include was not specified in the records provided. Any evidence of authorization for arthroscopic right shoulder decompression and distal clavicle resection was not posit specified in the records provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home continuous passive motion (CPM) device; initial period of forty-five (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), 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 (updated 05/04/15) Continuous passive motion (CPM).

**Decision rationale:** Request: Home continuous passive motion (CPM) device; initial period of forty-five (45) days. ACOEM and CA MTUS chronic pain guidelines do not address this request. Therefore ODG was used. As per cited guideline, "Continuous passive motion (CPM): Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. " Rotator cuff tears: Not recommended after shoulder surgery or for nonsurgical treatment. The request was for arthroscopic right shoulder decompression and distal clavicle resection. A surgery or procedure related to this injury was not specified in the records provided. An operative note was not specified in the records provided. Evidence that the patient was certified for a arthroscopic right shoulder decompression and distal clavicle resection, was not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. Detailed response to previous conservative therapy was not specified in the records provided. The medical necessity of the request or Home continuous passive motion (CPM) device; initial period of forty-five (45) days is not fully established for this patient. The request is not medically necessary.

**Surgi-Stim unit; initial period of ninety (90) days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Galvanic Stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) page 114.

**Decision rationale:** Surgi-Stim unit; initial period of ninety (90) days. According the cited guidelines, electrical stimulation (TENS), is "not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Recommendations by types of pain: A home-based treatment trial of one month may be appropriate for neuropathic pain and CRPS II (conditions that have limited published evidence for the use of TENS as noted below), and for CRPS I (with basically no literature to support use). "According the cited guidelines, Criteria for the use of TENS is "There is evidence that other appropriate pain modalities have been tried (including medication) and failed. " A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. The physician noted, a left shoulder

arthroscopy, subacromial decompression, acromioclavicular joint decompression, and repair of the labrum and/or rotator cuff was denied. A surgery or procedure related to this injury was not specified in the records provided. An operative note was not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. Detailed response to previous conservative therapy was not specified in the records provided. Evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. Evidence of neuropathic pain, CRPS I and CRPS II was not specified in the records provided. The patient has received an unspecified number of PT visits for this injury. Detailed response to previous conservative therapy was not specified in the records provided. In addition a treatment plan including the specific short- and long-term goals of treatment with the Surgi-Stim unit was not specified in the records provided. The records provided did not specify any recent physical therapy with active PT modalities or a plan to use Surgi-Stim unit as an adjunct to a program of evidence-based functional restoration. The medical necessity of the request for Surgi-Stim unit; initial period of ninety (90) days is not fully established in this patient. The request is not medically necessary.