

<b>Case Number:</b>	CM15-0112493		
<b>Date Assigned:</b>	06/12/2015	<b>Date of Injury:</b>	08/22/2012
<b>Decision Date:</b>	09/23/2015	<b>UR Denial Date:</b>	05/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/10/2015

### 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 30 year old female, who sustained an industrial injury on 8/22/12. She reported initially sustaining head and shoulder injuries after a slip and fall. The injured worker was diagnosed as having partial-thickness rotator cuff tear of the right shoulder; bilateral subacromial impingement syndrome; acromioclavicular degenerative joint disease. Treatment to date has included physical therapy (x24); acupuncture (x12); cortisone injection to the left shoulder; medications. Diagnostics included diagnostic ultrasound bilateral shoulders (3/26/14). Currently, the PR-2 notes dated 4/13/15 indicated the injured worker was seen in this office for a comprehensive orthopedic second opinion surgical consultation. The provider notes the injured worker has failed conservative treatment of physical therapy, acupuncture, left shoulder cortisone injection and anti-inflammatory/analgesic medications. She has been advised that surgery may be indicated. The injured worker reports her pain level is 7-8/10. A physical examination is documented indicated her left side shoulder is worse than the right shoulder impingement syndrome and acromioclavicular degenerative joint disease but there is no apparent left rotator cuff tear. There was a diagnostic ultrasound study of the bilateral shoulders conducted on 3/26/14 that revealed a partial-thickness rotator cuff tear of the right shoulder, bilateral subacromial impingement syndrome and acromioclavicular degenerative joint disease. These notes document he advised the injured worker to continue conservative management verses surgical intervention as an alternative. He notes she is an excellent candidate for the arthroscopic left shoulder evaluation; decompression; distal clavicle resection, labral tear and rotator cuff debridement. This surgery was authorized along with postoperative physical therapy. However,

the provider additionally requested authorization for a continuous passive motion (CPM) initial 45 days; Coolcare cold therapy unit; Surgi-stim unit initial 90 days; shoulder immobilizer with abduction pillow and pre-operative medical clearance.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Pre-op medical clearance:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Preoperative testing, general.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter under Preoperative Testing, general.

**Decision rationale:** Based on the 04/13/15 progress report provided by treating physician, the patient presents with bilateral shoulder pain, left worse than right, rated 7-8/10. The request is for PRE-OP MEDICAL CLEARANCE. RFA not provided. Patient's diagnosis includes partial-thickness rotator cuff tear of the right shoulder; bilateral subacromial impingement syndrome; acromioclavicular degenerative joint disease. Physical examination on 04/13/15 revealed left side shoulder is worse than the right shoulder impingement syndrome and acromioclavicular degenerative joint disease but there is no apparent left rotator cuff tear. Treatment to date has included physical therapy (x24); acupuncture (x12); cortisone injection to the left shoulder; medications. The patient may return to modified work, per 04/27/15 report. MTUS and ACOEM Guidelines do not address this request. ODG, Low Back Chapter under Preoperative Testing, general states, "Preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status." "Criteria for Preoperative lab testing: Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management. A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants." Per progress report dated 04/13/15, treater states that the patient failed conservative treatment of physical therapy, acupuncture, left shoulder cortisone injection and anti-inflammatory/analgesic

medications, and is advised that surgery may be indicated. UR letter dated 05/29/15, arthroscopic left shoulder evaluation, decompression, distal clavicle resection, labral tear and rotator cuff debridement; along with postoperative physical therapy were authorized. Treater states in 04/13/15 report "Prior to surgery, the patient will require pre-operative medical clearance." ODG guidelines do support an evaluation to determine what is needed for pre-operative assessment. Therefore, the request IS medically necessary.

**Associated surgical service: Continuous Passive Motion (CPM) initial 45 days: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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 under Continuous passive motion devices (CPM).

**Decision rationale:** Based on the 04/13/15 progress report provided by treating physician, the patient presents with bilateral shoulder pain, left worse than right, rated 7-8/10. The request is for ASSOCIATED SURGICAL SERVICE: CONTINUOUS PASSIVE MOTION (CPM) INTIAL 45 DAYS. RFA not provided. Patient's diagnosis includes partial-thickness rotator cuff tear of the right shoulder; bilateral subacromial impingement syndrome; acromioclavicular degenerative joint disease. Physical examination on 04/13/15 revealed left side shoulder is worse than the right shoulder impingement syndrome and acromioclavicular degenerative joint disease but there is no apparent left rotator cuff tear. Treatment to date has included physical therapy (x24); acupuncture (x12); cortisone injection to the left shoulder; medications. The patient may return to modified work, per 04/27/15 report. ACOEM and MTUS do not discuss Continuous passive motion devices. ODG, Shoulder Chapter under Continuous passive motion devices (CPM) states: "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." Per progress report dated 04/13/15, treater states that the patient failed conservative treatment of physical therapy, acupuncture, left shoulder cortisone injection and anti-inflammatory/analgesic medications, and is advised that surgery may be indicated. UR letter dated 05/29/15, arthroscopic left shoulder evaluation, decompression, distal clavicle resection, labral tear and rotator cuff debridement; along with postoperative physical therapy were authorized. Treater states in 04/13/15 report "At the appropriate time following surgery, authorization is requested for home continuous passive motion (CPM) device for an initial period of 45 days to assist in restoring range of motion... I have found CPM invaluable for restoring motion at an early stage, which cannot be gained in any other way. In my experience, early motion gains reduce the risk of restrictive adhesions and soft tissue contracture and allow earlier return to activities of daily living with better motion outcomes." In this case, the patient does not have a diagnosis of adhesive capsulitis, for which CPM devices are indicated. ODG does not recommend CPM for rotator cuff tears, which the patient has been diagnosed with. Though treater discussed post-operative use to prevent adhesions, this patient does not meet the criteria set by ODG for the use of a CPM device. Therefore, the request IS NOT medically necessary.

**Associated surgical service: shoulder immobilizer with abduction pillow:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder Chapter, Postoperative abduction pillow sling.

**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 under Immobilization.

**Decision rationale:** Based on the 04/13/15 progress report provided by treating physician, the patient presents with bilateral shoulder pain, left worse than right, rated 7-8/10. The request is for ASSOCIATED SURGICAL SERVICE: SHOULDER IMMOBILIZER WITH ABDUCTION PILLOW. RFA not provided. Patient's diagnosis includes partial-thickness rotator cuff tear of the right shoulder; bilateral subacromial impingement syndrome; acromioclavicular degenerative joint disease. Physical examination on 04/13/15 revealed left side shoulder is worse than the right shoulder impingement syndrome and acromioclavicular degenerative joint disease but there is no apparent left rotator cuff tear. Treatment to date has included physical therapy (x24); acupuncture (x12); cortisone injection to the left shoulder; medications. The patient may return to modified work, per 04/27/15 report. ODG guidelines Shoulder Chapter, Immobilization, state: "Not recommended as a primary treatment. Immobilization and rest appear to be overused as treatment. Early mobilization benefits include earlier return to work; decreased pain, swelling, and stiffness; and a greater preserved range of joint motion, with no increased complications." Postoperative abduction pillow sling topic states: "Recommended as an option following open repair of large and massive rotator cuff tears." Per progress report dated 04/13/15, treater states that the patient failed conservative treatment of physical therapy, acupuncture, left shoulder cortisone injection and anti-inflammatory/analgesic medications, and is advised that surgery may be indicated. UR letter dated 05/29/15, arthroscopic left shoulder evaluation, decompression, distal clavicle resection, labral tear and rotator cuff debridement; along with postoperative physical therapy were authorized. Treater states in 04/13/15 report "the patient will also require a shoulder immobilizer with abduction pillow for support following surgery." However, the requested treatment is for post-operative use following arthroscopic procedure. The patient is not going to have "open repair of large and massive rotator cuff tears" for which an abduction pillow would be indicated. This request is not in accordance with ODG. Therefore, the request IS NOT medically necessary.

**Associated surgical service: Surgi-stim unit initial 90 days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Galvanic Stimulation; Interferential Current Stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** Based on the 04/13/15 progress report provided by treating physician, the patient presents with bilateral shoulder pain, left worse than right, rated 7-8/10. The request is for ASSOCIATED SURGICAL SERVICE: SURGI-STIM UNIT INITIAL 90 DAYS. RFA not provided. Patient's diagnosis includes partial-thickness rotator cuff tear of the right shoulder; bilateral subacromial impingement syndrome; acromioclavicular degenerative joint disease. Physical examination on 04/13/15 revealed left side shoulder is worse than the right shoulder impingement syndrome and acromioclavicular degenerative joint disease but there is no apparent left rotator cuff tear. Treatment to date has included physical therapy (x24); acupuncture (x12); cortisone injection to the left shoulder; medications. The patient may return to modified work, per 04/27/15 report. [www.vqorthocare.com/products/orthostim-4-surgistim-4](http://www.vqorthocare.com/products/orthostim-4-surgistim-4) MTUS pages 118 to 120, Interferential Current Stimulation (ICS) Section states: "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." Per progress report dated 04/13/15, treater states that the patient failed conservative treatment of physical therapy, acupuncture, left shoulder cortisone injection and anti-inflammatory/analgesic medications, and is advised that surgery may be indicated. UR letter dated 05/29/15, arthroscopic left shoulder evaluation, decompression, distal clavicle resection, labral tear and rotator cuff debridement; along with postoperative physical therapy were authorized. Treater states in 04/13/15 report "in addition, authorization is also requested post-operatively for a Surgi-Stim unit for an initial period of 90 days and a Coolcare Cold Therapy unit. These modalities will assist in managing post-operative swelling, edema, and pain...Surgi- Stim unit provides continuing functional and symptomatic benefit at 90 days use, then purchase of the unit would be recommended." 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. The request is for 90 days as stated, which exceeds guideline recommendation. Therefore, the request IS 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 ODG, Online Version, 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) Shoulder Chapter under Continuous-flow cryotherapy.

**Decision rationale:** Based on the 04/13/15 progress report provided by treating physician, the patient presents with bilateral shoulder pain, left worse than right, rated 7-8/10. The request is for ASSOCIATED SURGICAL SERVICE: COOLCARE COLD THERAPY UNIT. RFA not provided. Patient's diagnosis includes partial-thickness rotator cuff tear of the right shoulder; bilateral subacromial impingement syndrome; acromioclavicular degenerative joint disease.

Physical examination on 04/13/15 revealed left side shoulder is worse than the right shoulder impingement syndrome and acromioclavicular degenerative joint disease but there is no apparent left rotator cuff tear. Treatment to date has included physical therapy (x24); acupuncture (x12); cortisone injection to the left shoulder; medications. The patient may return to modified work, per 04/27/15 report. ODG, Shoulder Chapter under Continuous-flow cryotherapy states: "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." ODG, Knee & Leg Chapter under Continuous-flow cryotherapy states: "recommended as an option after surgery for up to 7 days including home use." Per progress report dated 04/13/15, treater states that the patient failed conservative treatment of physical therapy, acupuncture, left shoulder cortisone injection and anti-inflammatory/analgesic medications, and is advised that surgery may be indicated. UR letter dated 05/29/15, arthroscopic left shoulder evaluation, decompression, distal clavicle resection, labral tear and rotator cuff debridement; along with postoperative physical therapy were authorized. Treater states in 04/13/15 report "in addition, authorization is also requested post-operatively for a Surgi-Stim unit for an initial period of 90 days and a Coolcare Cold Therapy unit. These modalities will assist in managing post-operative swelling, edema, and pain...." However, the request as stated does not specify duration of use. Guidelines support the use of requested unit for up to 7 days postoperatively. Per 04/13/15 report, the implied duration appears to be 90 days, since Surg- Stim unit is requested for 90 days in same discussion. Therefore, the request IS NOT medically necessary.