

<b>Case Number:</b>	CM15-0120369		
<b>Date Assigned:</b>	06/30/2015	<b>Date of Injury:</b>	05/24/2013
<b>Decision Date:</b>	08/25/2015	<b>UR Denial Date:</b>	06/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/22/2015

### 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 37 year old female, who sustained an industrial injury on May 24, 2013, incurring right shoulder injuries. She was diagnosed with right shoulder impingement syndrome, subacromial decompression and biceps tenodesis. She underwent a surgical distal clavicle excision. Right shoulder Magnetic Resonance Imaging revealed rotator cuff tendinopathy, supraspinatus tear and glenoid chondral thinning. Treatment included physical therapy, home exercise program, pain medications, steroid injections, anti-inflammatory drugs, transcutaneous electrical stimulation, sleep aides and muscle relaxants and work restrictions and modifications. Currently, the injured worker complained of persistent pain in the bilateral upper extremities, throbbing pain in her forearm and hands and numbness in her ring and small fingers. The treatment plan that was requested for authorization included a purchase of a cold therapy unit, purchase of post-operative abduction brace, 21 days rental of a continuous passive motion machine and a pain pump purchase.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase of 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, 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) Pain Chapter under continuous flow cryotherapy.

**Decision rationale:** The patient was injured on 05/24/13 and presents with left shoulder pain, bilateral upper extremity pain, and right shoulder pain. The request is for Purchase of Cold Therapy Unit for postoperative pain control. There is no RFA provided and patient has "regular work [with] unrestricted duties". The MRI of the right shoulder revealed rotator cuff tendinopathy, supraspinatus tear, and glenoid chondral thinning (date of MRI not provided). The MTUS and ACOEM Guidelines do not discuss water therapy units. ODG Guidelines Pain 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 a 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 patient has tenderness to the anterior shoulder region, inclusive of the subacromial space, inclusive of the acromioclavicular joint, a limited right shoulder range of motion, a positive Neer impingement sign, a positive Hawkin's impingement sign, a positive cross-chest test, a positive AC joint compression test, and a positive Speed's test. She is diagnosed with right shoulder impingement syndrome, subacromial decompression, and biceps tenodesis. The 06/08/15 report states that the patient chooses to proceed surgically and a formal surgical request is being at this time for a right shoulder arthroscopic acromioplasty with distal claviclectomy and debridement. In this case, ODG Guidelines recommend a cold therapy unit for postoperative recovery. However, the patient's surgery has not been yet scheduled nor authorized. Furthermore, ODG Guidelines allows the cold therapy unit for up to 7 days including home use; however, the request is for a purchase. The requested cold therapy unit is not medically necessary.

**Purchase of Post Operative Abduction Brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter under Abduction pillow brace.

**Decision rationale:** The patient was injured on 05/24/13 and presents with left shoulder pain, bilateral upper extremity pain, and right shoulder pain. The request is for Purchase of Post Operative Abduction Brace for postoperative pain control. There is no RFA provided and patient has "regular work [with] unrestricted duties". The MRI of the right shoulder revealed rotator cuff tendinopathy, supraspinatus tear, and glenoid chondral thinning (date of MRI not provided). ACOEM guidelines Shoulder chapter, Chapter: 9, page 204: Under Options, it allows for "Sling for acute pain," under rotator cuff tear and as a "sling for comfort," for AC joint

strain or separation. Regarding Abduction pillow brace, the ODG under the shoulder chapter states "Recommended as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs". The patient has tenderness to the anterior shoulder region, inclusive of the subacromial space, inclusive of the acromioclavicular joint, a limited right shoulder range of motion, a positive Neer impingement sign, a positive Hawkin's impingement sign, a positive cross-chest test, a positive AC joint compression test, and a positive Speed's test. She is diagnosed with right shoulder impingement syndrome, subacromial decompression, and biceps tenodesis. The 06/08/15 report states that the patient chooses to proceed surgically and a formal surgical request is being at this time for a right shoulder arthroscopic acromioplasty with distal claviclectomy and debridement. The treater recommended an Abduction brace for post-operative use. The ACOEM guidelines provide support for the use of abduction brace for rotator cuff tears and ODG states recommended as an option following rotator cuff repair. However, the patient's surgery has not been yet scheduled nor authorized. The request is not medically necessary.

### **21 Days Rental of Continuous Passive Motion (CPM) Machine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**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.

**Decision rationale:** The patient was injured on 05/24/13 and presents with left shoulder pain, bilateral upper extremity pain, and right shoulder pain. The request is for 21 days rental of Continuous Passive Motion (CPM) MACHINE for postoperative pain control. There is no RFA provided and patient has "regular work [with] unrestricted duties". The MRI of the right shoulder revealed rotator cuff tendinopathy, supraspinatus tear, and glenoid chondral thinning (date of MRI not provided). The ACOEM and MTUS guidelines 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". The patient has tenderness to the anterior shoulder region, inclusive of the subacromial space, inclusive of the acromioclavicular joint, a limited right shoulder range of motion, a positive Neer impingement sign, a positive Hawkin's impingement sign, a positive cross-chest test, a positive AC joint compression test, and a positive Speed's test. She is diagnosed with right shoulder impingement syndrome, subacromial decompression, and biceps tenodesis. The 06/08/15 report states that the patient chooses to proceed surgically and a formal surgical request is being at this time for a right shoulder arthroscopic acromioplasty with distal claviclectomy and debridement. In this case, ODG Guidelines recommend CPM for patients with adhesive capsulitis, which the patient does not present with. Therefore, the request is not medically necessary.

**Pain Pump purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**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 Pain pump.

**Decision rationale:** The patient was injured on 05/24/13 and presents with left shoulder pain, bilateral upper extremity pain, and right shoulder pain. The request is for Pain Pump Purchase for postoperative pain control. There is no RFA provided and patient has "regular work [with] unrestricted duties". The MRI of the right shoulder revealed rotator cuff tendinopathy, supraspinatus tear, and glenoid chondral thinning (date of MRI not provided). Regarding post-operative pain pump for the shoulder, ODG guidelines states "Not recommended. Three recent moderate quality RCTs did not support the use of pain pumps". The patient has tenderness to the anterior shoulder region, inclusive of the subacromial space, inclusive of the acromioclavicular joint, a limited right shoulder range of motion, a positive Neer impingement sign, a positive Hawkin's impingement sign, a positive cross-chest test, a positive AC joint compression test, and a positive Speed's test. She is diagnosed with right shoulder impingement syndrome, subacromial decompression, and biceps tenodesis. The 06/08/15 report states that the patient chooses to proceed surgically and a formal surgical request is being at this time for a right shoulder arthroscopic acromioplasty with distal claviclectomy and debridement. Due to lack of support from guidelines, the requested pain pump purchase is not medically necessary.