Case Number:	CM15-0129376		
Date Assigned:	07/15/2015	Date of Injury:	12/03/2013
Decision Date:	08/11/2015	UR Denial Date:	06/15/2015
Priority:	Standard	Application Received:	07/03/2015

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: Preventive Medicine, Occupational Medicine

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 60-year-old female who sustained an industrial injury on 12-3-13. Diagnoses are right shoulder strain-rotator cuff tendonitis, moderate acromioclavicular joint changes-per x-ray, diagnostic ultrasound studies of the bilateral right shoulders dated 9-24-14 revealed right acromioclavicular joint hypertrophy-osteophyte formation-narrowing of subacromial regions space; right rotator cuff tendinitis (supraspinatus), right subacromial region and subdeltoid bursitis; right wrist sprain, DeQuervains tenosynovitis-thumb (basal) osteoarthritis per x-rays, lumbar spine musculoligamentous sprain-strain with multilevel spondylosis, moderate facet osteoarthritis at L3 through S1 per MRI 5-28-14, right knee sprain-patellofemoral arthralgia, right Achilles tendinitis, and psychiatric complaints-deferred. In a progress report dated 6-12-15, the primary treating physician notes complaints of right shoulder pain with difficulty with overhead activity, loss of grip strength, pushing, pulling, gripping, grasping and difficulty sleeping due to pain, stiffness, soreness and aches. Exam of the right shoulder reveals tenderness to palpation over the supraspinatus tendon, biceps, upper trapezius muscle, acromioclavicular joint and subacromial region. Range of motion of the right shoulder in degrees is as follows; flexion 90, extension 38, abduction 96, adduction 36, internal rotation 28, and external rotation 56 and impingement test is positive. The treatment plan is right shoulder arthroscopy is pending, she is unable to proceed with additional lumbar epidural steroid injection until she has medical clearance from her private medical doctor, and continue to follow up for psychiatric consultation. Previous treatment includes bilateral L4-S1 medial branch blocks, Dilaudid, Neurontin, Ultracin, moon boot, heel cup, surgery, 12 sessions of chiropractic

treatment with no relief, 6 acupuncture treatments with no relief. Work status is temporary total disability. The requested treatment is Surgi-Stim Unit -initial 90 day rental, Home CPM (continuous passive range of motion) 45 day rental, and Coolcare -Cold Therapy Unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgi-stim unit (initial 90 day rental): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

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/Hyperstimulation Analgesia Section.

Decision rationale: The MTUS Guidelines do not address the use of localized intense neurostimulator therapy. Per the ODG, hyper stimulation analgesia is not recommended until there are higher quality studies. Initial results are promising, but only from two low quality studies sponsored by the manufacturer, therefore, the request for Surgi-stim unit (initial 90 day rental) is determined to not be medically necessary.

Home - CPM (continuous passive motion) 45 day rental: 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), Treatment Index, 13th Edition (Web), 2015, 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 Section/Continuous Passive Motion (CPM).

Decision rationale: MTUS guidelines do not address the use of CPM for shoulder injuries; therefore, other guidelines were consulted. The ODG guidelines do not recommended the use of CPM for shoulder rotator cuff problems, but do recommend CPM as an option for adhesive capsulitis, up to 4 weeks, 5 days per week. CPM is not recommended after shoulder surgery or for nonsurgical treatment for rotator cuff tear. An AHRQ Comparative Effectiveness Review concluded that evidence on the comparative effectiveness and the harms of various operative and non-operative treatments for rotator cuff tears is limited and inconclusive. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain, and one study found no difference in range of motion or strength. CPM treatment for adhesive capsulitis provides better response in pain reduction than conventional physical therapy. The CPM group received CPM treatments for 1 hour once a day for 20 days during a period of 4 weeks. The PT group had a daily physical therapy treatment including active stretching and pendulum exercises for 1 h once a day for 20 days during a

period of 4 weeks. All patients in both groups were also instructed in a standardized home exercise program consisting of passive range of motion and pendulum exercises to be performed every day. In both groups, statistically significant improvements were detected in all outcome measures compared with baseline. Pain reduction, however, evaluated with respect to pain at rest, at movement and at night was better in CPM group. In addition, the CPM group showed better shoulder pain index scores than the PT group. Because adhesive capsulitis involves fibrotic changes to the capsuloligamentous structures, continuous passive motion or dynamic splinting are thought to help elongate collagen fibers. This injured worker is utilizing CPM for the treatment of rotator cuff injury, and not adhesive capsulitis, which is not supported by the ODG. The request for home - CPM (continuous passive motion) 45 day rental is determined to not be medically necessary.

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, Treatment Index, 13th Edition (Web), 2015, 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) Cold Compression Therapy Section/Continuous-flow Cryotherapy Section.

Decision rationale: The MTUS Guidelines do not address the use of cold compression therapy for the shoulder. The ODG does not recommend the use of cold compression therapy for the shoulder, as there are no published studies. Continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to seven days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. In this case, the use of cold therapy is warranted, however, this request does not state the length of treatment requested, therefore, the request for Coolcare - cold therapy unit is determined to not be medically necessary.